SENATE—*Monday, August 15, 1994*

(Legislative day of Thursday, August 11, 1994)

The Senate met at 10 a.m., on the expiration of the recess, and was called to order by the President pro tempore [Mr. BYRD].

The PRESIDENT pro tempore. Today, as the Senate offers prayer to the Supreme Lawmaker of the universe, we will be led by the Senate's Chaplain, the Reverend Dr. Richard C. Halverson.

Dr. Halverson, please.

PRAYER

The Chaplain, the Reverend Richard C. Halverson, D.D., offered the following prayer:

Let us pray:

Behold, how good and how pleasant it is for brethren to dwell together in unity!—Psalm 133:1.

"The Senate is the living symbol of our union of states."—Inscribed on west wall of Dirksen Senate Office Building.

Eternal God, Lord of history, Governor of the nations, the present situation gives America an opportunity to observe democracy at its best. Sometimes the democratic process seems like an irresistible force meeting an immovable object; yet, however slow and tedious, it is infinitely more desirable than a monarchy or a dictatorship. In the words of Winston Churchill, "Democracy is the worst form of government * * * except for all the other forms of government." We thank Thee, Lord, for a political system which guarantees the best for the most.

Infinite Lord, the needs, desires, opinions of 250 million people, hundreds of cities and counties, 50 States, thousands of organizations and institutions—not to mention global crises—converge on the 100 Members of the Senate who must somehow find resolutions. We thank You, mighty God, for the 100 Senators representing 50 States, many different backgrounds, views, and convictions, who struggle, often under great pressure and frustration, to arrive at solutions.

We thank You, gracious God, for patient, fair, dedicated leadership during these highly pressurized days. It must have been like this during the Constitutional Convention with many resisting independence, many opposed, and many supporting a strong, central government. We recall that, at the suggestion of the wise Ben Franklin, they resorted to prayer. Cover the Senate with divine love, grace, and wisdom as the Members work their way through this very complex democratic process.

In Jesus' name who is the Prince of Peace. Amen.

RECOGNITION OF THE MAJORITY LEADER

The PRESIDENT pro tempore. The majority leader is recognized.

THE SCHEDULE

Mr. MITCHELL. Mr. President, I say to Members of the Senate, the Senate today will continue debate on the health care reform legislation and the pending amendment by Senator DODD regarding health insurance for children. That amendment has been pending since late Friday afternoon.

I have repeatedly asked our Republican colleagues to permit a vote to occur on that amendment. So far, I have been unable to gain their assent. As every Senator knows, under the rules of the Senate, any one Senator or a group of Senators may prevent action from occurring by the tactic of unlimited debate and discussion.

While I welcome the opportunity for every Senator to make opening statements and to address any aspect of the bill that he or she wishes, I believe that it is appropriate and timely for the Senate now to begin to vote on amendments, and I hope very much that we will be able to proceed to voting on the pending amendment today.

I have invited Senator DOLE and our Republican colleagues that if they have any amendments that they wish to offer, we welcome those; if not, we have other amendments which we are prepared to offer.

In the event that we cannot reach agreement with respect to this amendment, the only recourse available to me is to require a vote on a procedural matter and, although that is not my preference, if no other alternative is available, that is what will be done. Under an order entered on Saturday, such a vote is scheduled for 5 p.m. today.

I will be discussing the matter further with our colleagues and hope to have an announcement with respect to the schedule during the day today.

The Senate will be in session Monday through Saturday on this legislation. As I have previously stated on many occasions, the Senate will take up the crime bill conference report when that is passed by the House. I do not know when that will occur and, therefore, cannot now state precisely anything with respect to the timing of that legislation. But that is a very important measure, and we will interrupt this debate for that measure after its passage in the House and after it is sent to the Senate.

Mr. President, Senator DASCHLE will be acting as manager on behalf of Senator MOYNIHAN, who is necessarily absent to attend a ceremony at the White House at which the President will sign into law legislation establishing the Social Security Administration as an independent agency. That is an important measure on which Senator MOYNIHAN has worked for many years, and I think it appropriate that the President pay tribute to him in connection with that signing ceremony.

Senator MOYNIHAN has for many years been the leader of our Senate and I believe our Nation in protecting and enhancing the Social Security System, and this legislation is further action in that regard.

Mr. President, I would like to make just one comment about my legislation, if I might, that has been the subject of a lot of debate here. Enough of our colleagues have made their opening statements, and they are identical in many respects, all of them focusing on a single theme that suggests that my bill creates a Government-run insurance system. Some heated rhetoric has been used which I believe has been inaccurate. But I want to and I will, of course, address the subject in a great deal more detail. But I myself am leaving to attend the White House ceremony of which I just spoke. But I just want to make one point in that regard: Saying something over and over again does not by itself make it true.

This is a desk before me, and if I repeat a thousand times that this is a horse, it will not become a horse. It might persuade some people of that, because we all know that repetition can create that impression, but it does not make it so.

We went through a similar exercise just a year ago when the President's economic plan was before the Senate.

Over and over again, our colleagues said of that plan that it would raise everyone's taxes and be a tax on small business. Neither of those statements were correct. Although I acknowledge they were successful in persuading the American people, because polls showed that a large majority of Americans believed their income tax rates would go up as a result of that legislation and believed that it would impose a tax on all small businesses. Neither statement was true. They were proven to be untrue, but the mere repetition of those

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

statements did persuade a majority of Americans even though the statements were incorrect.

Much the same thing is occurring now.

Let me make clear that my bill does not provide for a Government-run health insurance system. It is a voluntary system which builds upon the current private insurance market. Indeed, under my bill, one of the largest Government programs—Medicaid—would be virtually abolished and 25 million Americans who are now in the Medicaid program, a Government Program, would be taken out of that program, which would be virtually abolished, and would be encouraged to purchase private health insurance in the same system of insurance payment and coverage that most Americans are now in.

So not only is it not a Government-run program, it is just the opposite. It is a private program, a voluntary system, in which citizens are encouraged and assisted in the purchase of health insurance. In that respect, it is similar to the legislation offered by Senators DOLE and PACKWOOD. Both programs provide for insurance market reform; very similar in that respect. Both provide subsidies to people to assist them in purchasing insurance in the private market as most people do now.

The Congressional Budget Office has estimated that, if my plan is adopted, 95 percent of Americans will have health insurance by the year 2000. And if that occurs, as both the Congressional Budget Office and I believe it will, then there will be no requirement on anyone under any circumstances to purchase health insurance.

And so I want to make clear that, while it is going to be repeated over and over again, it is simply not correct. The fact of the matter is, I believe we should build upon the current system, take those steps to extend insurance to those who do not now have it, and provide health security to the millions of Americans who have health insurance but who do not have health security. Because right now, most Americans who have health insurance face the risk that if they get sick, their policy could be canceled. Incredible as that seems, that is what can happen under the current system.

A person buys health insurance to cover himself and his family in the event they become sick. And then, if they become sick—the very reason they bought the insurance—the policy can be canceled. It is an incredible catch-22 in which American families find themselves and which my legislation seeks to correct. And those same families, and others like them, do not know if the premiums can be doubled or tripled at any time. They have no assurance that the policy will be renewed. They may lose their insurance if they change jobs or if the employer chooses to discontinue coverage.

So it is important for Americans to understand that what is involved here is not just extending insurance to those who do not now have it.

Of equal, indeed of greater, importance, it provides security to those Americans who do have insurance so that they will know that their policy cannot be canceled at any time and they will have what all American families should have—guaranteed private health insurance to provide access to high quality health care in our system.

What we must do is adopt a mechanism which will permit us to fix what is wrong and to permit what is right to stay intact. I believe my legislation does that through a voluntary system in which 25 million Americans who are now in a Government program will be encouraged and assisted to buy private health insurance, and that Government program will be virtually abolished.

I know there will be arguments to the contrary, and I welcome the debate. But I hope all Americans will keep that in mind during this debate.

Mr. President, I yield the floor.

The PRESIDENT pro tempore. The Chair seeks advice from the majority leader on two points.

Is the time that has been consumed to be charged against time under the control of Senator DASCHLE or is it to be charged against the majority leader's time?

Mr. MITCHELL. The time under the control of Senator DASCHLE.

The PRESIDENT pro tempore. The Chair also takes guidance from the majority leader on another point.

Is the time between now and 5 p.m. today to be used for debate only, or would an amendment to the amendment in the first degree be in order and would an amendment to the underlying legislation be in order?

Mr. MITCHELL. Mr. President, it was, I believe, Senator DOLE's intention and mine that this time is to be used for debate only, unless and until we reached agreement and announce an agreement to the contrary.

The PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. WALLOP. There is, is there not, an amendment pending?

Mr. MITCHELL. Yes.

The PRESIDENT pro tempore. There is an amendment in the first degree, but it is open to amendment in the second degree.

Mr. MITCHELL. Although we did not address that in the order, I believe it was Senator DOLE's intention, and with which I am agreeable, pending discussions that he and I will have later in the day, that the debate will continue and then we will, if we can, reach an agreement and we will announce that probably sometime early this afternoon.

The PRESIDENT pro tempore. Without objection, it is so ordered. The Chair thanks the majority leader for his clarification.

HEALTH SECURITY ACT

The PRESIDENT pro tempore. The Senate will now resume consideration of the bill, S. 2351, which the clerk will report.

The legislative clerk read as follows:

A bill (S. 2351) to achieve universal health insurance coverage, and for other purposes.

The Senate resumed consideration of the bill.

Pending:

Mitchell amendment No. 2560, in the nature of a substitute.

Dodd amendment No. 2561 (to amendment No. 2560), to promote early and effective health care services for pregnant women and children.

Mr. WALLOP addressed the Chair.

The PRESIDENT pro tempore. The Senator from Wyoming.

Mr. WALLOP. Mr. President, I inform the Chair that I have been asked by Senator PACKWOOD to stand in for him while he goes to the same meeting.

With that, I yield such time to the Senator from Oklahoma as he chooses to take.

The PRESIDENT pro tempore. The Senator from Oklahoma [Mr. NICKLES] is recognized for such time as he may consume.

Mr. NICKLES. Mr. President, I thank my friend and colleague from Wyoming. I just express my sadness that this is his last year in the Senate, because he has been an outstanding Member of the Senate on a lot of issues, including this issue. I appreciate his work and contribution not only on behalf of the State of Wyoming but also for our country, as well.

Mr. President, many have taken to the floor and many of us have had a great deal of discussion on the issue of health care. It is not a new issue, just because we now have a 1,443-page bill. It is a complicated issue. But we have been working on it for a long time. A lot of us have been working on this issue for a long time.

Last year, I introduced the consumer choice health care bill. We had 25 cosponsors, one-fourth of the Senate as cosponsors on that legislation to try to remedy some of the problems that the majority leader just discussed.

The majority leader mentioned problems where some people might have insurance and might lose it because they become ill. We addressed that in our bill. We addressed it in the Dole bill. I hope that we will pass legislation to solve that problem this year.

We addressed problems where some people might not be able to buy insurance because they have a preexisting illness. And I think a lot of us have found that is the case in our families.

A few years ago, I found out that I had a little cancer; no big deal. But I remember, I asked the doctor what that meant. He said, "Well, you won't be able to buy insurance."

Well, he was wrong, because I am under the Federal employee system.

And Federal employees' preexisting illnesses are covered, so I was covered.

They do that for 10 million employees and their families, why can we not do that for everybody in America? So we took care of that in the bill I introduced. It is taken care of, frankly, in the bill Senator DOLE offered and I believe in Senator MITCHELL's bill, and we ought to pass that this year. We ought to pass some things that would help solve some of the problems.

I know when President Clinton and Mrs. Clinton are on the road all the time they are talking about somebody who has a terrible health care problem and has a preexisting illness, they cannot get insurance or they lose their insurance because they really become ill, and they had a catastrophe, and the insurance rates go sky high. We ought to solve those problems and we can, and we can solve those in a bipartisan fashion.

I might mention, I think it was a couple years ago, now, we passed legislation that Senator Bentsen and others were working on that incorporated solutions to those problems. Those are positive, significant solutions. We hear people going to the floor and saying, "We have 37 million people who are uninsured, let us help those people." We should, and there are differences of opinion on how we should do that. Some would propose it through a mandate—that was in President Clinton's proposal. It is in Congressman GEPHARDT's proposal. Senator MITCHELL has a kind of delayed mandate. He says if you do not get to 95 percent, then the mandate would hit or would be triggered.

I might mention it would be triggered in a State like mine and probably West Virginia and a lot of States. You would have a big mandate, mandating on every business and every individual that they have to provide a Government-defined package.

I disagree with that solution. I do not disagree with the idea of trying to help those people who need help. I do not disagree with the idea, or the goal of trying to have everybody have some type of health care—which, frankly, they do have today. Not everybody has prepaid health insurance. Not everybody has a prepaid health care system. But everybody has some degree of health care.

Mr. WALLOP. Will the Senator yield for question on the mandate issue he just raised?

Mr. NICKLES. I will be happy to.

Mr. WALLOP. Is it not true that under the Mitchell-Clinton mandate provision, once it triggers, it triggers State by State setting up real distortions in job markets between States that are mandated and States that are not? Would that not be the case?

Mr. NICKLES. The Senator is correct. I will mention that in a moment. But the Senator is right. It is a State-by-State mandate, so if you have one State at 95 percent the mandate would not be triggered. If you have a State that is 90 percent, it would be triggered. And you can easily see a scenario where business becomes flexible and jumps from one State to another, in several States, where you would have businesses fleeing the mandate because, frankly, a lot of businesses cannot afford the mandate. It is very expensive. I will get into the cost of this in just a moment.

The problem I am trying to address is: Let us identify the problem and then let us try to solve it. If 37 million people do not have insurance, how long do they not have it for? Are these chronically uninsured people? Because we hear this term and it sounds pretty large in a population of almost 260 million people in the country.

I did a little homework on it. Actually I did not, the Urban Institute did the homework. It said the figure of 37 million uninsured is a snapshot, at one point. Their study found that most of the people who lose their insurance get it back within a very short period of time. The study found half of the uninsured go without coverage for less than 5 months. That is interesting: 70 percent get coverage back within 9 months. Only 19 percent are uncovered for 2 years or more.

So, 19 percent of 37 million people, that is probably about 7.5 million people who are what I would categorize as chronically uninsured or very hard to insure for whatever reason. I have already said let us solve some of those problems; let us make sure that if somebody has a preexisting illness, they can buy insurance. Let us make sure somebody is not dumped out of the insurance market because they have become ill. This will solve some of the problems.

Let us solve some of the portability problems so if somebody changes jobs or loses jobs, for whatever reason, they can continue to be insured. That is in the legislation I have cosponsored in Senator DOLE's package, and I imagine in most of the bills. We can pass that. We can pass that today or this year. So we can make some positive, constructive steps toward alleviating the problem for the people who are uninsured.

I might mention, too, for the people who are uninsured, the 37 million, 70 percent will have insurance within 9 months. What is the biggest category of people who are uninsured? Young adults, age 18 to 24, who are the most vulnerable to lapses in coverage. I could go on. Most of them had coverage within a month or couple of months of losing the coverage. They might be in a situation like I was. I had a daughter who turned 22. She graduated from college; she was going to go to graduate school. So there might have been a lapse had we not moved pretty quickly to get her enrolled. She was no longer covered under my family plan so we had to enroll her on her own coverage. We did that. But it would be easy to see how that coverage could lapse for a month or two.

But that is not really the problem. That is not the reason why we need a Federal solution. And that is not the reason why we need legislation today. What about some of the others? Not everyone who lacks insurance is poor. According to the Employee Benefit Research Institute, nearly half the uninsured have incomes of more than $20,000, and 17 percent have incomes of more than $40,000. So I think we can exclude those individuals who, for whatever reason, have decided they did not want insurance or they are going to wing it, they are going to gamble that they will be healthy forever. I do not think that is the need for a Federal program. I do not see that as the solution.

Let us solve some of these problems that would help it, but I hope, let us make a rule in the Senate, or try to make sure, that we do no harm. We have quality health care in this country. I know every person in this body—but I would also say in America today—has been a beneficiary to some extent of the best quality health care system in the world; or certainly their families have, for whatever reason. Let us try to make sure we do no harm to this quality health care system.

Some people say, "Wait a minute, we compare the United States to other industrialized countries and we spend more per capita, we spend more per person, we spend more in total amount of dollars—the amount of money we spend in health care today in the United States alone is bigger than the economies in many other countries." That is probably true. But we have an asset, we have a real quality health care system in this country. Let us not emulate countries that do not have quality health care. Let us not emulate countries that cannot give care. Let us not emulate countries that have care, it is cheap—I would guess they would say in the former Soviet Union they had health care for everybody. But I would also venture to say most people would say it is not very good; or in East Germany or some places. Some people say, "Let us emulate Germany or Canada or Great Britain." Again, they have care. They have a government program that covers everybody. But I venture to say if you looked at the waiting lists, if you look at the Government rationing, if you look at the delays that are involved, if you look at the Government improvement that is needed and so on, you find many of those people are coming to the United States as a last resort to get quality health care.

If we emulate their systems, where are Americans going to go? What kind of fallback do we have? The Canadians

are coming south. They come into the United States to get health care if they really need it.

The doctor says, "You need a bypass but we have already had our quota. You need it within 6 months or 12 months. We know you are going to need it. We will get around to it, but we cannot do it in this Province now. This is in the fourth quarter of the year and, frankly, we are about out of money. So, elective surgery, we have said, in this Province in Canada, we are going to postpone until next year."

A lot of people might not be willing to take that risk so they come to the United States. If we get into that scenario, where would Americans go?

So I just make a final plea that we do no harm. Let us seriously consider the legislation we have before us. Let us take a look at it. Let us look at all the proposals and pass positive legislation. At the same time, let us not pass legislation that we are going to regret.

I was very involved in the debate—which was a few years ago—the so-called catastrophic health insurance for senior citizens that was going to provide catastrophic coverage. Basically, although we called it catastrophic, really it was a medigap policy. Medicare paid for some, but it did not pay for some of the deductibles. We said we will have a policy to cover that. And a lot of people already had it; actually 75 percent. Senior citizens had medigap policies through the private sector. Congress came in and said we do not care if you have it or not, some people do not, so we are going to mandate it on everybody.

We mandated a Federal program on all senior citizens, whether they wanted it or not. We did not give them an opt-in or opt-out. I might mention we passed it in the Senate and we did make it voluntary, but when it came back from conference, it came back mandatory for everyone.

I debated a couple of hours on that legislation, debated against our friend and colleague, now Secretary of the Treasury, Senator Bentsen. I said this is moving in the wrong direction. Why do we not target our efforts at the 25 percent of senior citizens who do not have Medigap policies and then target the portion of that one-fourth of the senior citizens group who did not have it and could not afford it? Some people did not want it who could afford it. Why should we have a Federal program to cover them? We did not need to.

But no, we did not do that. We did not put a means test on it. What we did do is have a big tax increase. We are going to cover everybody. We do not care if you have private coverage or not, we are going to duplicate it with a Federal program and pay for it with a Federal tax. And at least the Finance Committee was honest and direct and said this is going to be a tax; this is going to be a 25-percent surcharge on your income tax.

I predicted on the floor when we were debating that that when the bill comes due, senior citizens are going to rebel, and they did. Because they rebelled, we repealed it a year later, and I think correctly so.

I hope we do not make that same mistake in this legislation, but I also hope that we are very direct with the American people. I think we ought to tell people what it is going to cost. We ought to tell people what is in the legislation. We ought to do it now before we pass it, not after we pass it and find out, "Oh, I didn't know that was in the legislation." We ought to do it now. We ought to find out what is in the legislation.

Some of us have complained about this process. I have complained about the process and, I will say, going back from the moment of its conception within this administration. The process started out very partisan. Mrs. Clinton and President Clinton put together a task force of over 500 people. They met. Now it appears they met illegally and there is a lawsuit pending. I notice there was an article in the New York Times on Wednesday, August 10. It talked about the "White House Seeks Settlement of the Health Suit."

They have been sued and, frankly, it looks like they are going to lose. I will not read the entire article, but I will insert it in the RECORD.

It says:

The Clinton administration urged a group of doctors today to agree to a swift settlement of their lawsuits seeking disclosure of the records and working papers of Hillary Rodham Clinton's task force * * *

For more than a year, the White House has resisted disclosing the records. But administration officials said today they wanted the lawsuit settled as soon as possible, in part to avoid the need for having Mrs. Clinton and Ira Magaziner, a White House aide who coordinated the work of the task force, to testify.

The 12-member task force and its staff of more than 500 developed most of the President's proposal to control health care costs and guarantee health insurance for all Americans. Major parts of the proposal have been incorporated in the legislation developed by the Democratic leaders of the Senate and House, Senator George Mitchell and Representative Richard Gephardt.

And it goes on in the article. I will just read the last part:

The groups contend—

Talking about Mr. Magaziner.

that he was wrong when he said in an affidavit in March 1993 that all members of the staff of the task force were Government employees. In fact, the three groups said, many staff members came from business in the health care industry that stood to profit from the President's plan.

Mr. President, I am troubled that Presidential adviser, Mr. Magaziner, who coordinated the task force, testified in an affidavit, a sworn statement, that these were all Government employees if they were not. If you had special interest groups who were writing this package and putting a lot of this together—and I am going to mention this in my speech a little later—if they were doing that against the law, that bothers me, and it bothers me that he would sign an affidavit saying they were all Government employees if they were not.

I know the Presiding Officer, the chairman of the Appropriations Committee and President pro tempore, believes people should speak the truth. I am bothered by Mr. Altman's statements before the congressional committee. I am bothered anytime anybody deliberately misleads Congress and does not state the truth, particularly when they are in high levels of power, or abuses that power, and particularly if they are trying to pass legislation or implement legislation that would have a significant impact on my constituents.

I see a lot of things in this bill that I am very troubled by. Where did they come from? We have not had a hearing on this bill. I am troubled by the process of where we are.

Mr. President, I ask unanimous consent that this article be printed in the RECORD.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

[From the New York Times, Aug. 10, 1994]

WHITE HOUSE SEEKS SETTLEMENT OF HEALTH SUIT

(By Robert Pear)

WASHINGTON, Aug. 9.—The Clinton Administration urged a group of doctors today to agree to a swift settlement of their lawsuit seeking disclosure of the records and working papers of Hillary Rodman Clinton's Task Force on National Health Care Reform.

For more than a year, the White House has resisted disclosing the records. But Administration officials said today that they wanted the lawsuit settled as soon as possible, in part to avoid the need for having Mrs. Clinton and Ira C. Magaziner, a White House aid who coordinated the work of the task force, testify.

The 12-member task force and its staff of more than 500 developed most of the President's proposal to control health costs and guarantee health insurance for all Americans. Major parts of the proposal have been incorporated in the legislation developed by the Democratic leaders of the Senate and the House, Senators George J. Mitchell and Representative Richard A. Gephardt.

NEGOTIATIONS ACCELERATE

Justice Department lawyers asked the plaintiffs to start discussing the possibility of a settlement last Thursday, and the negotiations have accelerated this week. The Government appears to be willing to disclose thousands of pages of task force records, but has been reluctant to pay lawyers' fees for the plaintiffs' lawyers.

It is not clear why the Administration is so eager to reach a settlement this week, although the Administration apparently wants to announce a settlement before Congress takes any votes on health care legislation. In addition, the Administration may also want to make sure that Republicans cannot use the litigation in political attacks on the White House.

The plaintiffs in the case, including the Association of American Physicians and Surgeons, have repeatedly asserted that "special interests" from the health care industry influenced the task force at meetings from which the public was excluded. The White House has rejected those assertions.

On July 25, the Administration told a Federal judge that the President's health plan had been devised by "an anonymous horde" of more than 500 people operating in creative confusion with no organized structure and no fixed roster of members. As a result, the Justice Department asserted, the task force was not a formal advisory committee and did not have to divulge its working papers or financial records.

The Judge, Royce C. Lamberth of the Federal District Court here, said last month that he would hold a full trial to examine the composition and operations of the task force. The trial would determine whether the panel and its staff operated legally in excluding the public from meetings from January to May 1993, when it was disbanded.

The plaintiffs, three groups of doctors and consumers, have also asked the judge for a contempt citation against Mr. Magaziner.

The groups contend that he was wrong when he said in an affidavit in March 1993 that all members of the staff of the task force were Government employees. In fact, the three groups said many staff members came from businesses in the health care industry that stood to profit from the President's plan.

Mr. NICKLES. Mr. President, I am concerned about the legislation we have before us. I read a lot. I took home the first print, and it was 1,400-some pages. I worked on it. I had my yellow magic marker. I was going through pages, as hard as I could, and I was marking pages. I was putting question marks down.

I have studied legislation a lot. I have introduced legislation. And I know it is not easy, and I know it is not simple. But last Monday, I believe, was the first day we had the first print. We call it the Mitchell-Clinton print 1. Then there was 2. Then there was 3. I am not sure if this is the amendment or modification of the second or third, but it has over, I think, 133 sections that were changed. I believe that is between the first print and the second print.

All it mentions is the section number and a change. "These following sections have been modified since initial printing." I was working off the initial printing. Mr. President, I invested a lot of hours on that initial printing, the first one that came out. I wanted to know as much about it as anybody. I signed a little card saying I am going to read this bill before I vote on it favorably, and I am going to. Now we have another bill. We have to start over.

There are over 100 sections that have been changed. What is in this bill? Was it reported out of the committee? No. Was this bill reported out of the Finance Committee? No. Was it reported out of the Labor Committee? Has there been a hearing on this bill? No. Does anybody really know what is in this bill? Maybe a few staff members; maybe some of the White House advisers. I am not sure. But I know there is a lot of garbage in the bill. There are a lot of provisions in the bill, in my opinion, that would be very, very negative.

Again, I said let us do no harm. Let us make sure that whatever we do does no harm.

I have listed several little things—I call them little things, I think they are rather significant—provisions in the Clinton-Mitchell bill that, in my opinion, are very bad. I want to talk about them just a little bit. I will go through each one.

First, it denies consumer choice. I know I heard my colleague and friend, Senator MITCHELL, say this bill is a voluntary system. I know if you read section 1003, it says "Protection of Consumer Choices." It makes you think you can keep your own plan. I will just run through this.

This bill imposes a one-size-fits-all benefit package on all Americans. That means people in West Virginia have to buy the same plan that people in Oklahoma buy or in New York City. The Government is going to define the benefit package for everybody in America. So if you want to have a little less, something a little more affordable, that is not an option. So you lose a lot of choices.

It imposes $300 million in new taxes. That is CBO's figure. Dr. Feldstein mentions it is $100 billion per year. I will talk about that in a minute.

It hurts the middle class.

It imposes a hidden tax on the young, a big hidden tax.

It results in substantial job losses. If you put this kind of mandate, this mandate, some people say, if it happens—and I guarantee you, in a lot of States that have 80-some percent of coverage, you are not going to get to 95 percent coverage under the terms of this plan, so you are going to have a mandate—that mandate will cost jobs.

It creates big incentives for people not to work. People are going to realize, "The Government is going to be providing this." We are going to be more than doubling the size of Medicaid. I wonder if people realize that. I know the chairman of the Appropriations Committee has wrestled with expansion of entitlement plans, the fact that Congress actually has less and less control over the Federal budget because we pass programs that grow on automatic pilot; that under the Clinton-Mitchell bill, we will have a massive expansion of people eligible to receive Federal assistance called subsidies. By the year 2004 there will be 117 million people subsidized under this proposal. That is a massive expansion and more than doubles the Medicaid population or people eligible to receive assistance from the low-income side.

It creates an enormous bureaucracy—some people have already talked about this, so I will try not to be too repetitive—over 250 new bureaucracies in boards and commissions, some of which are very, very powerful. Some of them have enough power to say this benefit will be covered and this benefit will not. Some will say we need cost containment and, therefore, this agency or commission is going to do something to contain costs.

Does that mean price controls? In all likelihood, it would.

It creates a huge new entitlement program, actually several new entitlements programs. I will touch on that in a moment.

It vastly increases the number of people on governmental assistance.

It promotes and subsidizes abortion. I know I heard Senator DOLE and others say we are going to have to talk about this for a while. There is no status quo on abortion. This is a program that says we are going to subsidize abortion, whether you want to or not. We are going to have the Federal Government pay for it. We do not do that today under our Federal system under Medicaid. We have passed language for years, and we call it the Hyde language. Basically, it says we are not going to use Federal money to pay for abortions unless it is necessary to save the life of the mother, or in cases of rape or incest.

This says, no; this is a fringe benefit and pays for everything. And it also says you have to have access to abortion everywhere in the country. I would say in West Virginia, and in 80 percent of the counties in the country, they do not provide abortion. This is going to mandate that every place in America or every person in America have access to the whole list of standard benefits coverage, including abortion. It massively promotes and subsidizes abortion throughout the country.

It also caters to special interests. And by special interests, I am talking about the AARP. I will talk about some provisions that were written, in my opinion, probably specifically for AARP, and for organized labor. They are getting a lot of support from those groups as well as from the groups that support and promote abortion.

It would even have some language, I will tell the Presiding Officer, that expands civil rights statutes to include protection for sexual orientation. That is interesting. Most people are not aware of that, but it is in the bill.

And it has no real malpractice reforms. Frankly, the bill, instead of having positive malpractice reform, would override about 20 laws that are on the books that try to limit abuses in the cost of providing limitations on insurance costs. It overrides those. It does more harm than good. And I think that is a serious mistake.

Mr. President, while I am going through the Mitchell-Clinton bill and

trying to describe some of the things I think that are wrong with it, let me just state at the outset, again, I want some positive health care reform. I want to cover preexisting illness. I want to make sure that people do not lose insurance if they become ill. I want portability where people can take their insurance from job to job or have control of insurance.

I think one of the big problems we have today in health care is that individuals, the people who buy, the consumers, are not really at the table. Somebody else is paying for it—well, Government is paying for it or the employer is paying for it. So they do not care how much it costs.

I think the individual should have some responsibility, and, unfortunately, the Clinton-Mitchell bill, the Gephardt bill, President Clinton's original proposal move just the opposite direction. Instead of having individual responsibility, they make more people dependent. Instead of giving individual rights and choices, they have the Government making those decisions.

Mr. President, let me just start out by stating I think it is vitally important that all people always give the facts and tell the truth all the time. I am bothered by this statement. This was in the President's statement just recently, August 3. He said: "You can keep your own plan or pick a better one."

Well, that is not accurate, and it is unfortunate to have the President of the United States say you can keep your own plan or pick a better one, but he is not telling the complete truth, in my opinion, in that statement. And that bothers me a lot.

Let us just take this first part: "You can keep your own plan." Let me just give you an example. I hate to use personal examples, but I know not one better.

I used to run a company, Nickles Machine Corporation. We had a plan. Can I keep our plan? No. Why? Because we self-insure. Under the President's plan, firms that have fewer than 500 employees cannot self-insure. So the President's statement is false as far as DON NICKLES and Nickles Machine. We cannot keep our own plan because, under the Clinton-Mitchell bill, it says, if you self-insure and you have less than 500 employees, your plan is illegal. You cannot self-insure.

I think that is really wrong. I think self-insured plans have a lot to offer. We have been able to get our costs down, and we are able to do it a lot less expensively than the President's plan. I am bothered by that.

I mentioned the cost. I will just pull that out. One of the reasons why some people self-insure is they can do a better job for less expense. Under the Clinton-Mitchell package, the cost for a family estimated by CBO—these are 1994 dollars, and you know it will be higher later—is right at $6,000 for a two-parent family—$6,000. They are going to mandate that or tell everybody, if you are going to have insurance, here is what you have to have. They have a standard benefit plan that tells you you cannot buy something less.

In other words, in this little bill—it just happens to be section 1201 and 1202, I believe, unless they changed the sections on this, too. Oh, yes, "standard benefit package." "General description. Standard benefit package." Then they have given enormous power to the National Health Benefits Board, which is section 1211 through 1217. This board is going to determine what has to be in everybody's plan. And we give them about 20 pages that says what Congress says it should be in this plan, and it has a lot of coverage, a lot of coverage you may want, maybe coverage you do not want. I mentioned it has abortion. You have to have it in your plan whether you want it or not under this bill—no opt out, no choice, no conscience clause or anything. It says, you have to have it.

I object to that. I object to it on moral grounds, but I object to Government thinking they have to define every package in America. What in the world makes some of our colleagues and this administration think that they can design a health care package better than anybody else in America? What in the world gives them the right or the power to think they know best in what should be in everybody's health care plan? And we are not talking about a core benefits package. We are not talking about a minimal benefit package, just the bare essentials so that people just get by, something very economical.

No, we are talking about a comprehensive, extensive, expensive benefit package that lots and lots of people in America will not be able to afford. And they are going to mandate. It is mandated under President Clinton's original proposal, it is mandated under the Gephardt proposal, and it will be mandated under the Clinton-Mitchell proposal because we will not get to 95 percent. Maybe we will, but I doubt that we will. I know in a lot of States we will not get there.

To give you an example, I have heard people talk about Hawaii. Hawaii had 90 percent coverage before they went to an employer mandate. And now they have massive subsidies. They have 20 years under an employer mandate and they got up to 94 percent. They are still not up to 95. So I have some questions.

I know CBO says they think they can make it. I think they are doing a little wishful thinking. I think under Senator MITCHELL's package those mandates are going to happen and there are going to be consequences to those mandates.

I might mention, too, looking at the rest of these premiums, for a single adult, the cost of that plan is $2,200. That is pretty expensive. It is especially expensive for young, single adults, and I might mention that as well.

Well, again, going back to President Clinton's comments, he said: "You can keep your own plan or pick a better one."

I just noticed, under the President's bill—I hope people look at it—if you have a cafeteria plan—and I know there are some unions in West Virginia that have cafeteria plans where you choose from a multitude of benefits—health care cannot be in a multitude or menu of benefits. I think cafeteria plans are great because you are putting consumers at the choice: Do you want to spend more money on health care or do you want to spend more money on vacation? Do you want to have more money to take home? You get to choose from a multitude of fringe benefits where employees then recognize the cost of health care. That is a good benefit for putting people at the table to recognize the benefits.

Those are outlawed under the President's plan. You cannot keep your own plan if you have a cafeteria plan in health care.

Wait a minute, Mr. President. You said on August 3 you can, but you cannot. He did not tell the truth. That is not the case. And that bothers me. Those plans are illegal under this bill.

The flexible spending accounts, which a lot of Americans have today, health care is not included in those flexible spending accounts. Again, millions of people have these types of plans.

In the cafeteria plan, well, just by changing this tax and not allowing health care in, they estimate, will raise $52 billion in 10 years. So we are talking about lots of employees, lots of individuals are going to lose that. They are going to lose flexible spending accounts. Again, a lot of people have that today. They are not going to be able to have it tomorrow.

What about the people who have a high-cost plan and maybe these are union plans, maybe they are plans people have and they are designed and very generous.

The President says you can keep your own plan. What he did not tell you, there is a big tax on that plan, a 25-percent tax surcharge.

Well, wait a minute, you are not going to be able to keep that plan probably if you find out it is going to cost you 25 percent more. Think about that. And so maybe legally you could keep it, but the real results are economically, if you find out there is a tax surcharge on it of 25 percent, you are not going to keep it. And you have a lot of union plans, you have a lot of other

plans in the country today, if they happen to be a little bit better than average, anything that is above that average that is determined by a beautiful bureaucratic disaster formula, they are going to have a big tax, a 25-percent tax. So the Tax Code is going to take away that nice benefit they have because people are going to design their plans away from it.

What about if you have a plan that does not conform to the Government plan?

I mentioned one-size-fits-all. What if you say, No. I don't believe in the one-size-fits-all in the Government package. We have a good package, and we are happy with it and we think we can do it more economically. I am going to opt out.

I heard Senator MITCHELL say this is voluntary. If this is voluntary in Nickles Machinery, since I am still involved, we opt out. I do not want any part of it. If it is voluntary, throw it away, and our employees are happy. Guess what? We can do it for $2,400 per family, not $6,000 per family. So I opt out.

What happens to us? If you do not conform to the standard benefit package, there is this 35-percent tax. Wait a minute. Think about that again. President Clinton said you can keep your own plan. He did not tell you that, if you keep your own plan, there will be a 35-percent tax if you did not conform to the Government standard benefit package. How can you keep your own plan, if you have a 35-percent tax?

Let us just assume that you have a plan that does not conform to the standard benefit package, but your plan is more generous. That is possible. You could have a tax surcharge because you do not conform, and you could have a 25-percent tax surcharge for excessive cost. That is a 60 percent additional marginal tax on the health insurance dollars because you said you do not want to play.

They said it is voluntary. Yes. It is a voluntary, with a gun at your head; big taxes; 25-percent tax if you have an expensive plan, and 35 percent tax if you do not conform.

You do not get to keep your own plan. It is not right. So you lose your cafeteria plan, your flexible spending account. If you have an expensive plan, you will be taxed for that. If you do not conform, they will tax you.

It has massive taxes in it. But they use the Tax Code to drive their idea that Government will control it. They will design your plan. This National Health Benefits Board will say what your plan is.

I know that most of our colleagues are not going to read this bill. I hope that they will just take a little time and read the powers that we have granted to the national health benefits board. That is just one of 50 new boards and commissions that are set up and have so much power.

I urge the Presiding Officer, it is not that many pages to read that one section. If we can get other colleagues to read about some of the powers that we are giving to this board and the cost containment board; enormous powers. If they make recommendations, we are telling Congress or future Congresses that we are going to consider this legislation on an expedited basis, in some cases without the right to amendment, and in some cases without the right to filibuster.

So here is this board, a seven-member board appointed by the President. It outlines all of that in here; a seven-member board with all this power to make their decisions. And then they are going to tell Congress we need legislation. Congress has to consider that legislation on an expedited basis without extended debate. That limits your right to amend it.

I know many of us feel we should have that right. Why in the world should we pass legislation today that is going to take away that right and obligate future Congresses? Not everybody is going to be here 5 years from now. I may or may not be here 5 years from now, I don't know.

I am bothered by trying to pass a law that is going to restrict future Congresses as this bill would propose. I think that would be a serious mistake.

This imposes new taxes. I mentioned a few of them; $300 billion in new taxes. I mentioned a couple of the taxes that are used as a hammer to make everybody conform. I hope people look at those because I know when I have heard taxes, I heard most of my colleagues mention the fact that, well, there is a tax of 1.75 percent tax premiums. That is going to drive excess premiums up in America.

So if you want to get health care costs down, this bill is not going to do it. It is going to drive them up. It is almost a 2-percent increase on every premium in America. So that means the costs are going up considerably.

If you have a health care plan that provides benefits that are more generous than what this commission says is appropriate, there will be a 25-percent tax. I might mention the tax is basically on incremental increases.

So if you have a pretty economical plan, and I mentioned that at my company it is $2,400. If we have to provide now this standard benefit, that will maybe cost about $6,000, as we increase. We will probably have to increase pretty rapidly. We are going to get hit with that 25 percent tax. If we have been more frugal, and more economical, we will be penalized. The more generous you have been and the more economically inclined you are, the more you will be taxed. This is a very interesting provision which I think is seriously wrong.

Mr. President, I heard some people who were discussing this bill say, "No. It has only four new taxes." There are 18 new taxes. I will not go through all of those. But I will put them in the RECORD so everybody can see them.

I cite code numbers, and the section number. Of course, they have changed bills on me three times. We are trying to put the latest code numbers in.

I mentioned premium tax, and excise tax. There is a big tax on part B premiums for upper-income people. There is an increase of 15.3 percent on the tax of income of certain S corporation shareholders and partners. There is a 2.9-percent health insurance payroll tax on all State and local work; Medicare coverage to such workers. They include employee income for Federal income and payroll tax purposes, and none is permitted for employer-provided health care coverage other than the standard benefit package and certain supplemental coverage.

So you have something that is not permitted under this standard benefit package. You are going to be taxed. Individuals are going to be taxed. They need to know it now. They need to know what is in this package now, not after it passes. They need to find out before it becomes law.

They are going to include employee income subject to Federal income payroll taxes for Federal benefits provided through a cafeteria plan for the flexible spending account. There are millions of people who have those benefits. They will now be taxed. They are going to lose those benefits because they are losing that tax incentive. We have not taxed health care costs in the past. But now, if you have that type of plan where an employee gets to choose what type and size of benefit they have, they are going to be taxed.

They place a limit on the deductibility of insurance for health insurance made in advance. I have already mentioned they impose a 35-percent tax, nondeductible excise tax, on employer-sponsored plans that do not conform to the standard benefit plan.

So again I go back to President Clinton who says that you can keep your own plan. You can, but you will pay a 35-percent tax if you do not conform to this plan, to this commission.

They make the decision and decide what benefits you should have or your employees should have. It is not you who decides it.

The reason I introduced the consumer choice bill is because I thought consumers should make that decision. They should not decide. You should. You know what is right for your family. I know what is right for my family, not some governmental panel that is also involved in social policy and other things. I want to buy what is the best deal. I want a good buy for my family. If I could it to for $2,400, or less, I want to do it. I am troubled by these costs because I will tell you, there are a lot of families that cannot

afford $6,000 per year. I know others say, "Wait a minute. They subsidize those." I say this bill really hurts the middle class because maybe they have insurance policies but now they will be taxed. Maybe they have insurance policies but they cannot buy cafeteria plans because they have to pay a premium tax. So the premium is going up by 2 percent. It is a big hit.

There is a hidden tax on the young. This is close to my home because I have four kids. I have a 24-year-old son. He is out of the home and on his own. I need to check with him about what his premium is. I know what my daughter's is. She turned 22, is still at home and not out on her own. She has a supplemental policy, and she is not on the family plan. It is about $500. I think it is $40 a year at the university, and that is not a great plan. It covers my daughter. It is going to cover us if she has a serious problem. Most of those cover serious problems, but not everything.

CBO has scored the Mitchell bill at $2,200 per adult. My daughter is an adult. It would quadruple her premium. That is a hidden tax, an increase on my daughter of $1,700. She cannot afford it. Frankly, I would pay that insurance bill. She is not on her own. My son is on his own. Maybe he can afford it now. There are a lot of 24-year-olds, and 28-year-olds that cannot afford $2,200. They should not have to pay that. They should be able to buy another plan, if they can. Maybe they are young and healthy. Maybe they are not going to the hospital, or maybe they will not see a doctor. They should not have to pay over $2,000. But under the Mitchell bill they have to. We have community rating, and that is a serious mistake. It is a hidden tax.

Mr. President, I want to insert in the RECORD an article by Martin Feldstein who worked in the previous administration, and he talks about the tax increase in the Mitchell bill. It is entitled "A Hidden $100 Billion Tax Increase." Most of the figures we use are over a 10-year period of time. There are $300 billion in new taxes over a 9- or 10-year period of time.

Dr. Feldstein is talking about a $100 billion tax increase—that is per year, and these are direct taxes as scored by CBO. He adds that the hidden taxes are in community rating, which is in the Clinton bill.

I ask unanimous consent to have this printed in the RECORD at this point.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

[From the Wall Street Journal, Aug. 9, 1994]

THE SENATE'S HEALTH CARE FOLLIES—A HIDDEN $100 BILLION TAX INCREASE

(By Martin Feldstein)

President Clinton is increasing the pressure on Congress to enact a massive and irreversible entitlement program to subsidize health insurance and redistribute income. The tax cost for this largest-ever welfare expansion would top $100 billion a year at today's prices. That's equivalent to raising personal taxes across the board by nearly 20%.

Amazingly, the Senate Democratic leadership has managed to conceal this massive tax increase from the public. The legislative wrangling and public discussion have virtually ignored the cost of financing this spending explosion. Members of the business community have been so eager to avoid employer mandates that they have not considered the tax consequences of the pending legislation. And members of the general public have been so concerned about preserving their ability to choose their own doctors that they have not focused on what these plans would mean for their individual wallets.

CBO ANALYSIS

Although the Democrats have yet to agree among themselves on the details of the final plan, it is likely to be closely related to the Senate Finance Committee bill. (The recent proposal by Senate Majority Leader George Mitchell that President Clinton said he would accept is essentially an expanded version of the committee's plan.) To understand the magnitude of the potential tax hike that would be required to finance such a plan, it's useful to look at the Senate Finance Committee bill and the recent analysis of it by the Congressional Budget Office.

Under the Senate Finance Committee plan, the government would pay the full cost of a standard private insurance premium for anyone below the poverty level and would provide a partial premium subsidy that declines with income between the poverty level and twice that income. The insurance premium would vary with family composition but would average about $2,000 per person. A single parent and child would receive a subsidy with income below $20,500, while a couple with three children would receive a subsidy with income up to $37,700.

More than 60 million individuals would be eligible for subsidies in addition to the 60 million already covered by Medicaid and Medicare. The Senate Finance Committee plan would raise insurance coverage by about 21 million individuals, bringing total coverage to 93% of the American population.

The budget analysis prepared by the CBO never states its estimate of the total additional cost that taxpayers would have to bear to finance the new insurance subsidies. But the CBO figures do imply that the public would be paying about $63 billion a year (at 1994 prices) by the year 2000 when the plan is fully operational, and estimates that I have made with the help of colleagues at the National Bureau of Economic Research indicate that the CBO figures understate the true cost by about $40 billion a year.

Most of the $63 billion tax burden implied by the CBO numbers is hidden in cost-shifting through insurance companies and providers of health services. Only a relatively small part of the financing plan is an explicit increase in the tax on tobacco products. A second small piece is a 1.75% excise tax on private health insurance premiums. Although this tax of $7 billion a year (at 1994 levels) would be paid by the insurance companies, they would pass it on in the form of higher premiums.

These higher premiums would be a direct tax on individuals who buy their own insurance. Companies would offset the higher premiums on the insurance that they provide to their employees by keeping wages lower than they would otherwise be. The true burden of the premium tax would therefore fall on everyone who is now privately insured.

The largest part of the financing is a hidden tax that is built into the plan to replace the current Medicaid program for the poor by subsidized private insurance. Medicaid provides much more generous benefits than the proposed standard insurance package, since Medicaid covers a broader range of services and has no out-of-pocket copayments. Although the government would pay the insurance companies the same subsidies for former Medicaid beneficiaries as it pays for everyone else, the proposed law would require the insurance companies to provide those who are currently eligible for Medicaid with the much more expensive coverage that they have today.

That complex maneuver would save the government about $29 billion a year on the current Medicaid program and would add that amount to the annual costs of the insurance companies. The insurance firms would in turn shift it to everyone who is privately insured in the same way they would shift the explicit premium tax.

A second very large hidden tax would result from reducing government payments to hospitals and other providers of Medicare services without any reduction in the care that they are expected to give. As a result, the hospitals and other providers would just raise their prices to patients and insurance companies. In the end, it would be the privately insured individuals who bear those costs in the form of higher insurance premiums and lower wages. At 1994 levels, this, cost-shifting burden is equivalent to at least a $13 billion annual tax.

In short, buried in the CBO numbers is a projection that the Senate Finance Committee plan would have a $63 billion annual cost (at 1994 price levels) and that all but what the CBO estimates to be $14 billion in cigarette levels would be obtained by hidden taxes in the form of cost-shifting through health care providers and insurance companies.

It's remarkable that the same politicians who have produced this $49 billion in hidden cost-shifting have the audacity to say that the public should support their plan in order to eliminate the much more limited cost-shifting that occurs under the existing system as hospitals pass on the cost of free care. Indeed, to the extent that hospitals are already giving free care, the increase in formal insurance coverage gives that much less to the currently uninsured and confirms that most of the plan's cost is to achieve income redistribution, not expanded health insurance.

The CBO report is careful to note that its estimates are "preliminary" and "unavoidably uncertain," and fully half of the report is devoted to discussing why there is "a substantial chance that the changes required by this proposal—and by other systemic reform proposals—could not be achieved as assumed."

My own analysis confirms that the CBO's caution is justified and that the CBO estimates understate the likely annual cost by at least $40 billion that would eventually have to be financed by higher taxes. A key reason is that there is no way to limit the premium subsidies to those who are currently uninsured. Those who are not buying their own insurance would automatically receive the government subsidy. Those who now receive insurance from their employers could qualify for an insurance subsidy by switching to an employment situation that paid higher cash wages instead of providing health benefits.

That subsidy would be worth a very significant $2,000 for a single mother with a child who earns $15,000; if she earns $10,000, the subsidy would be worth more than $4,000. It wouldn't take long for employers and employees to recognize that some combination of new pay arrangements, explicit outsourcing of some work, and individual job changes would be handsomely rewarded by the government.

There are now more than 30 million individuals who could qualify for a subsidy. The CBO estimate recognizes that the roughly six million of them who now buy their own insurance would receive government subsidies. But when it comes to those who are already insured by their employers, the CBO assumes that only about one-fifth of the income-eligible group would eventually choose to qualify for the subsidy, leaving $27 billion of potential subsidies (at 1994 levels) on the table. It seems totally implausible to me that employees and employers would permanently pass up subsidies of $1,000-plus per person that they could get by relatively easy changes in employment arrangements. When they do choose to qualify, taxpayers would have to pay an additional $27 billion to finance the plan.

The CBO calculation also ignores the effect of the subsidy phase-out between poverty and twice poverty on the incentives to work and to report earnings. The phase-out rule that gives a women with a child $4,660 of subsidy when she earns $10,250 and then takes away more than 40 cents of subsidy for every extra dollar that she earns is a powerful incentive to work less and to shift work to the underground economy.

The CBO's report acknowledges that "the effective marginal levy on labor compensation could increase by as much as 30 to 45 percentage points for workers in families eligible for low-income subsidies" so that "some low-wage workers would keep as little as 10 cents of every additional dollar earned." But then, quite incredibly, the CBO calculations do not take into account that this would reduce reported earnings, thereby cutting income and payroll tax receipts and raising the health insurance subsidies for which individuals are eligible. Estimates made at the NBER indicate that these reactions would reduce taxes and increase subsidies by a combined total of at least $17 billion a year.

This estimate makes no allowance for the impact of increased demand on health care costs in general. Extending insurance to at least 20 million people who are currently uninsured and giving private insurance to the more than 25 million nonaged Medicaid beneficiaries would inevitably raise the demand for health services and increase health care prices. But even without that, the analysis that I have laid out shows that the Senate Finance Committee bill would cost the American public more than $100 billion a year at today's prices. The Clinton-Mitchell plan for even broader coverage would cost even more.

INCOME REDISTRIBUTION

A cost of $100 billion-plus a year to increase the number of insured by 20 million means a cost to the taxpayers of more than $5,000 for each additional person insured—a cost of $20,000 for a family of four. Since the actual insurance premiums are $2,000 per person, it's clear that most of the tax dollars in these plans are for income redistribution rather than the expansion of insurance coverage.

The most fundamental social program in a generation should not be enacted without full and careful consideration of its costs. Once enacted, the benefits would be an irrevocable entitlement for nearly 100 million people.

The ability of the politicians to hide a $100 billion-plus tax increase is both amazing and frightening. Using mandates on insurance companies or mandates on all businesses as substitutes for direct taxes destroys the budget process and provides a ready way for politicians to deceive the voters. The politics of tax and spend has entered a new era when politicians can spend $100 billion a year and hide the taxes that we pay for those outlays.

If President Clinton and his congressional allies succeed in ramming this legislation through Congress in the weeks ahead, the American people will have lost not just $100 billion a year. We will also have lost our ability to check the excesses of the political process and to unmask the chicanery of the politicians.

If political leaders want to deceive the voters, the only safeguard is a democracy in which long and careful public debate and congressional hearings can expose such deception. Although Congress has held hearings on the now defunct Clinton plan and on the broad issues of health care, there has been no serious consideration of the cost and financing of the plans that have recently emerged. The American public deserves a chance to know what we are being asked to pay and what we will get for our money. We should be suspicious of any politician who says there isn't time for such a careful examination.

Mr. NICKLES. Mr. President, this bill would result in substantial job loss. That is very regrettable.

Mr. WALLOP. Before the Senator leaves that issue, would he yield for a question?

Mr. NICKLES. I would like to plow through, but go ahead.

Mr. WALLOP. Well, there is another tax in here that is pretty ominous, and that is the 15 percent tax on every health plan premium in the State where the Federal Government takes over a system. This is the voluntary program, of course, but if the Federal Government does not like what the State has done, it takes over the system and applies another 15 percent premium tax on health care plans.

(Mrs. FEINSTEIN assumed the chair.)

Mr. NICKLES. I appreciate my colleagues' work. As I mentioned in my introductory remarks, the Senator from Wyoming has done great work in the Finance Committee in trying to inform people of the potential harm in some of the taxes. He also stated—and I did not mention this one—there is also the provision that allows the States to have a tax on premiums as well. So you have a 1.75 percent Federal tax on premiums, but it says, States, you can tax the premiums, too; that power is yours. It results in substantial job loss. That is exactly right.

Mr. President, I used to have a janitorial service when I was working my way through school, and we did not provide health insurance for our employees. Our employees worked part time. Some were married. Under the Mitchell bill, a married couple with a child would be about $6,000. We had a couple of married couples in my janitorial service. The cost for that is about $4,400. I had single adults, students, which would cost me $2,200. I could not afford it, and they could not afford it. I know Senator MITCHELL and others say, "We are going to subsidize those people. We are going to provide them the same insurance everybody else has. We are going to subsidize them and take care of that problem so they do not need to worry."

I am on the Appropriations Committee and on the Budget Committee. We cannot afford that subsidy. We cannot afford to go down the subsidy trail that we are getting ready to take.

I mentioned that it is going to cost jobs. If you do not have the subsidies—that janitorial service did not earn enough money to pay those kinds of premiums. So if you are going to mandate something that costs $6,000 per family, figure the hours and divide that out, and you are talking about increasing the minimum wage by over $2.60 per hour—well, some of these jobs only pay a few dollars an hour. You are going to be pricing those jobs out of the marketplace. So not only will you not be giving people health insurance, you are basically passing a law that says unless you have a good enough income to pay minimum wage, other benefits and health insurance, which are enormously expensive, it is illegal for you to have a job. I will tell you that there are lots of jobs which some call menial jobs, sacking groceries, sweeping floors, or whatever—but I do not think any job is menial; I think it is preferable to no job. I would hate to pass laws in Congress that tell people it is against the law for them to have a job unless they meet a certain economic criteria. I would hate to pull that economic ladder up to where they cannot even get on it and climb that ladder. That is what we would be doing with the mandates.

Some people would say this is a mandate on employers and, therefore, it does not cost individuals. I just totally disagree with that. You put a mandate that costs $6,000 on a family, and if an employer has insurance and says, "OK, I cannot afford it, but I will go ahead and do it," I will tell you who pays for that; it is not the employers, it is the employees. They lose that money. That comes in the form of a pay raise that does not come or maybe in a direct reduction, but they will lose that money. So the employer mandate is 80 percent in the Gephardt bill, and it is 50 percent in the Clinton-Mitchell bill. It still comes out of employees' wages whether it is 20, 50 or 80 percent. If you are going to mandate that an employer has to provide this coverage, then you are looking at a very expensive provision that will cost employees. Does it cost employers? I doubt it. They will pass it on.

I also noticed the majority leader saying, "This is voluntary, we do not mandate anything on anybody." The company I used to manage provides health care, but we do it for a whole lot less than $6,000. So he is mandating that I provide a much more expensive health care plan. Eighty-five percent of the American people have health care insurance today, and maybe they can afford it, or barely afford it. But many have insurance that is a whole lot less expensive than this—$6,000. So maybe if they are paying $2,000, $3,000, you are going to mandate $6,000. That is a big increase. That is a hidden tax people have not talked about and that they have not looked at. If you mandate a Cadillac-type plan, or UAW-type plan, or AFL-CIO-type plan, a lot of businesses in California, Oklahoma, or wherever, cannot afford it. That is exactly what we are getting ready to do.

My little janitor service could not afford it. So if you had this kind of mandate—unless you greatly subsidize it—we would say, no way. Some people would say, wait a minute, we are not going to do that unless you have less than 25 employees. I do not think that is in the Gephardt bill. It was not in the original Clinton bill. They said, "We are just going to subsidize it." I am not looking for subsidies, and I know Congress cannot afford that.

I have mentioned that it creates an enormous bureaucracy of entitlement programs. Most people are not aware, and they really have not focused on the cost and expansion of Government that is in the Clinton-Mitchell package. The new entitlements are enormous. Let me just touch on them. The entitlement program of subsidies for health insurance premiums creates more than $1.1 trillion in 8 years. I would like my colleagues to think about that. We have had various expansions also in Medicare, Medicaid, and so on, over the years. But nothing has ever been proposed as large and as expansive as the proposal we are debating today.

This is a new entitlement program that will expand entitlements to 57 million new people over the next 10 years. Think about that. Fifty-seven million people will be receiving subsidies in 10 years that are not receiving subsidies today. That is more than doubling the eligibility of Medicaid. That bothers me. Where is that money coming from? It is going to be coming from taxpayers and, frankly, from senior citizens, because we take big reductions in Medicaid and Medicare to pay for these subsidies.

So we are creating new entitlements, and we are going to have a subsidy program for unemployed, a subsidy program for women and children. We are going to have subsidies for anybody at less than 200 percent of poverty. Well, 200 percent of poverty is about $30,000. So you are going to be subsidizing a lot of people. You are going to be subsidizing my daughter, and right now you are not. I pay for her insurance. It is $500, but you are going to be subsidizing her and charging her $2,200, when she can buy it for $500; but we are going to pay subsidies so she can help pay it. I would just as soon keep the Government out of it and let me buy her a $500 policy. We are going to mandate that she buy a $2,000 policy, and we are going to subsidize it and have the Government pay for it instead of the private sector, or myself, paying $500 as a family responsibility for my daughter. No, we are going to create a new Government program, and it will go up to $2,000. I think that is a serious mistake.

Under the Clinton-Mitchell bill, they have subsidies that go all the way up to people making $44,000 a year, which is 300 percent of poverty. Well, they have children. That is nice, but not everybody that makes $44,000 needs a Federal subsidy, but they are going to be on the Federal subsidy rolls. Again, it is estimated that 57 million new people will be receiving entitlements under the Mitchell bill by the year 2004. That is a massive expansion of Government.

So when I hear my colleagues say, "Oh, we do not have a Government program,"—no? We are going to be subsidizing 117 million people under the Clinton-Mitchell bill. Let me repeat that. Again, these are not my figures. These are figures that came from CBO. They said by the year 1997, only 3 years from now, we are going to be subsidizing 108 million people, and by the year 2004, 117 million people. CBO figures 117 million people will be receiving subsidies under the Clinton-Mitchell bill.

This is a massive expansion of Government, estimated to cost over $1.1 trillion, and people have not even looked at it. We make speeches that we need to balance the budget, we need to cut a couple hundred million dollars here and a couple million here, and talking about expanding entitlements $1.1 trillion over 8 years and bringing on 57 million new people to be subsidized, including my daughter, who does not need a subsidy, who did not ask for a subsidy, who wants to be left alone so she can buy a $500 policy instead of the Government selling her a $2,000 policy.

This is a ridiculous and massive raid on future generations. We cannot let that happen. Again, a lot of people just are not aware of the fact that it is in this program.

Mr. President, I mentioned as well this bill has a lot of things in it for various special interest groups, and it does. It makes you wonder who is supporting it and why.

One of the groups that has been very active in supporting passage of this bill is the abortion rights group, people who want to promote and encourage abortion, people who want everybody in America to have access to abortions. And that includes President and Mrs. Clinton. Unfortunately it is in the Mitchell package, and I am sure it will be in the Gephardt package. And I am sure in whatever package comes out of the conference committee, it will be in there as well.

This bill promotes, expands, and subsidizes abortion in a way untold of in our country. Let me just touch on a couple ways. I will even refer to section numbers.

A lot of people are not aware abortion will be covered as a part of every Federal benefit package. It is not today. Also, every worker will be required to pay for abortions with taxes and health care premiums. They are not today.

Federal employees can choose whether they want to have abortion coverage or not. Individuals can choose whether they want to buy a plan that covers abortion services or not. This says no. Under the Mitchell bill abortion services are covered whether you want them or not.

We might keep in mind this is supposed to be a health care bill. We also might keep in mind that abortion terminates the life of an unborn child. It kills an innocent unborn child, and this bill is saying we want it to be in every health care plan in America. That is serious. It is, whether you want it or not. There are no opt-out provisions—whether you want it or not.

Then it goes a little bit further and says we are going to subsidize it. Right now there is the Medicaid population, which is more than doubling under the Mitchell package. We do not subsidize abortion except for cases of rape and incest or in case of the mother's life in danger. In other words, for 99 percent of the abortions which are performed, we do not pay for them—we do not pay for them. We pay for very, very few on a Federal level, and I think that is appropriate.

This bill says no, no, you are going to pay for it; it is going to be in every health care package. Taxpayers, you are going to pay for it, too. Under the Medicare population, hey, we are going to put it in the plan. This is going to be a benefit. A lot of people will use it like a benefit. They will use it for birth control purposes. And just as in D.C. where the majority of abortions are performed on people who already had one, two, or three abortions, you will find this being the case if we put in this package.

That is really troubling, telling the people we are going to take taxpayers dollars to be used to pay to destroy an innocent unborn child. Unfortunately, it is in this package and it should not be in the package.

Then the bill has another massive expansion of abortion services that the bill requires. On page 77, section 1128, the bill requires federally-guaranteed

services, including abortion, to be uniformly available across the Nation, and readily accessible within each service region in each State.

Madam President, most States do not have abortion services everywhere. Most States have them in big cities. They do not have them in rural counties. This is going to mandate those services be available whether people want them or not. They are going to mandate that those services be available. That is a massive expansion and that is a massive promotion of abortion.

I think again it is a very, very serious mistake. That again is catering to a special interest group that has an agenda in this legislation, and that bothers me.

Madam President, there are some other special interest provisions in this bill, one of which I almost find interesting, but I hope that someone will pay a little attention to. Last week the American Association of Retired Persons endorsed this package. We note in reading the bill—I hope I am reading the right bill and the right section because we have three different Mitchell bills. I find a very interesting proposal in the Medicare prescription drug benefit. Even in the last few days, I heard many colleagues talk about what a great benefit this would be for seniors. Madam President, I am not so sure that is the case.

Now, we have before us a proposal to add a benefit to Medicare that once again many seniors already have through Medigap coverage. The bill does not even tell us what the bill will be. We do not know what the deductible will be or how it will compare to policies most seniors already have. Again, keep in mind 75 percent of the senior citizen population already have a Medigap policy. Many or most of them cover prescription drugs. Here is what the bill says about the deductible.

Section 2002 (a) state the deductible amount for purposes of subparagraph (a) the deductible amount is amount equal to the amount determined under iii.

That section begins on page 273. It states: For purposes of clause I the amount determined under the clause is (I) in 1999 the amount to be determined by the Secretary is such the amount determined will result in projected incurred spending administrative cost providing for payment under this for covered title outpatient I equal the intention target of $13.4 billion.

In other words, sometime in 1998 the Secretary will sit down and figure out how high to set the deductible. The overall cost of the new program to offer drug programming $14.4 million.

It means senior citizens will have to pay higher for a benefit that may be less generous than they now have under Medigap. Unless the organization understands this on the Mitchell bill—the AARP announced support for the bill on August 9.

My office, and I imagine other offices, was contacted by constituents who say that they want to share their belief that they do not agree with the AARP and they do not agree with this bill.

Mr. President, I do not know why they endorse the bill, but there is a very interesting provision on page 281. The provision authorizes the Secretary of HHS to establish a mail order pharmacy option under Medicare. Under this program the Secretary would solicit bids from various mail order pharmacies, enter into contract with one or more pharmacies to offer prescription drugs through the mail to beneficiaries.

In paragraph 6 (a) the payment amount for covered outpatient drug delivery through mail order pharmacy under such contract will be equal to the amount bid by such plan under the subparagraph instead of the payment limit determined in accordance with paragraph 4.

Paragraph 4 begins on page 277, line 13. This paragraph sets payment limits, price controls, for the maximum amount the Medicare will pay for prescription drugs, but mail order pharmacies are exempt from payment limits. In paragraph 4 they are exempt. So we are going to have price controls on drugs except for mail order pharmacies. That means mail order pharmacies who contract with the Secretary of HHS can charge Medicare more for a particular drug, than a pharmacy or other supplier.

So we are going to have price controls on everything else except mail order pharmacies. Mail order pharmacies would be given special treatment under this bill. They will be the only supplier of prescription drugs that charge more than the Government-imposed price controls.

What happens to a senior who ends up paying more for a drug through a mail order pharmacy?

Subparagraph 6(b) says on page 281, beginning on line 20: Such individuals receive from the Secretary a rebate or contribute toward individual cost sharing amount equal to 25 percent excess of payment limiting to reimburse seniors who get stuck, because we did not have price controls on mail order, and put it on everything but not pharmacy.

That is interesting. In other words, the Secretary which means, by the way, the taxpayer, will rebate 25 percent which the mail order pharmacy price exceeds the Government mandated price for the drug.

So every dollar that the mail order charges above the Government payment limit, the taxpayers are out 25 cents for rebate, and the Medicare beneficiary is out 75 cents. The mail order pharmacy pockets the dollar.

Madam President, I do not know why mail order pharmacies are made exempt from the stringent price controls imposed by Government in this legislation, nor why AARP endorsed the Clinton-Mitchell bill.

But I do note that the AARP operates one of the largest, if not the largest, mail order pharmacies in the country. It also is the case that any mail order pharmacy that wanted to contract with the Secretary will be exempt from price controls that apply to all other manufacturers and suppliers of prescription drugs. In this instance, with the special treatment of labor unions in this bill, a powerful special interest is receiving special treatment.

Does this go all the way back to the individuals who were putting this bill together in a cloud of secrecy and, quite frankly, in all probability illegally? Is this the reason this Times article alluded to the administration wanting to seek settlement of the health suit so people will not find out what went on behind closed doors? Is this the reason Ira Magaziner said all members of the staff were Government employees when they are were not? Is it a fact that there were actually people on the task force serving as staffers, putting this package together, working for special interest groups, maybe working for special interest groups like AARP, so they could exempt mail order pharmacies; maybe working for special interest groups like the National Organization of Women and other groups that are trying to promote and expand abortion access throughout the country; or maybe special interest groups like organized labor, which has certain exemptions from some of these actions I have alluded to?

Madam President, I will just mention one final comment, and that is in the area of medical malpractice reform. In the bill that I introduced originally, the consumer choice bill, we had medical malpractice reform. Senator CHAFEE's bill has medical malpractice reform. Senator DOLE's package has medical malpractice reform. The Clinton-Mitchell bill is a sham. It preempts State laws in 20 States, where they have done some good work to try curb medical malpractice. It preempts those.

Basically, it does nothing that would help to get down excessive litigation and excessive defensive medicine; again, a serious mistake.

I believe, again, it caters to special interest groups. The American trial lawyers support this legislation.

Madam President, I think there are several fatal flaws in this bill. I want to repeat one, this idea when I hear somebody say this bill is voluntary, but yet they tell me what benefits I have to provide. When I see CBO says the cost of this bill is $6,000 per family, I do not think that is voluntary. When they tell me if I have a benefits package that does not quite fit this one, that I am subjected to a 35-percent tax

surcharge, I do not think that is voluntary. When they tell me that if I have a high-cost plan there is a 25-percent tax surcharge that would push me down to have the same benefits that Government deems appropriate, I do not think that is voluntary. When they mandate that you provide abortion service when you do not want to, mandate that this be subsidized, and mandate they be in rural communities in North and South Dakota and Oklahoma, that is not voluntary.

Madam President, there is an enormous bureaucracy, there is enormous taxes, over $300 billion in taxes. There is enormous new spending, $1.1 trillion in new spending and new bureaucracies, over 50 new agencies and boards and commissions, some of which are worthless and some of which have enormous power, enormous power, where boards will be determining what benefits everybody in America will have, where boards will be determining the power of price controls, and so on. That is a serious mistake. That is a Government-controlled plan that we have before us. This is doing harm.

And I opened my comments saying, let us do positive health care reform that helps the system. Let us take care of preexisting illnesses. Let us make sure people are not terminated from their insurance because they become ill, or see their insurance rates skyrocket. Let us put in some portability provisions. Let us put in some real medical malpractice reform. Let us simplify the paperwork. We can do a lot of things in a bipartisan fashion and we have this year, but this is not the solution. This is a prescription for disaster. This is a prescription for big Government. This is a prescription for the quality of health care to go tumbling down, and we should not let that happen.

Madam President, I yield the floor.

Mr. DASCHLE addressed the Chair.

The PRESIDING OFFICER. Who yields time?

Mr. MOYNIHAN. I yield to the distinguished Senator from South Dakota such time as he may desire.

The PRESIDING OFFICER. The Senator from South Dakota is recognized for as much time as he will consume.

Mr. DASCHLE. I thank the distinguished Senator from the Finance Committee, the manager of the bill, and I appreciate having the opportunity to speak again on many of the issues that we began addressing last week.

I could not help but note the many references made by the distinguished Senator from Oklahoma to the Mitchell bill as a "Government plan." I would also note that last week a number of Members on both sides of the aisle expressed their concerns regarding the mischaracterization of either the Mitchell bill or Dole bill.

I was interested in a comment made by our Majority Leader just yesterday about references made on the other side of the aisle to a "Government health plan." I find it ironic that while the Republicans claim they oppose Government health plans they have not introduced, as far as I am aware, a bill to repeal Medicare, a Government plan. I do not know of any Member on the other side of the aisle who has proposed that we repeal FEHBP, the Federal Employee Health Benefits Plan, a Government plan. I do not know that anyone has introduced a plan or a bill or a proposal at this point to repeal the Veterans Administration, another Government plan.

As Members of Congress, when we visit the doctor, we go to Bethesda Naval Hospital or Walter Reed, both Government hospitals. When we need a doctor, we go to the Capitol physician, an employee of the Federal Government.

So, in essence, what my colleagues on the other side of the aisle seem to be telling the American people, is that Government is good enough for us but not for you. Government is good enough for us when we get sick, when our families get sick, when we have an emergency, but it is not good enough for you.

That would alone makes a very compelling argument about the kind of duplicity that occurs sometimes on the Senate floor, except for the fact that the Mitchell bill is not a Government plan. In fact, it is ironic that anyone would call it a Government plan since the 30 million Americans currently covered under Medicaid, a Government plan, would now be covered by private insurance.

What we are saying is that there ought to be some regulatory framework. And if it is not Government who creates that regulatory framework, who does?

Do we just turn over the entire system to the insurance industry for them to do whatever they wish? Do we turn it over to the doctors, the hospitals? How would it be if we let the airline industry run the entire system without any kind of oversight and regulatory control by the FAA. As we all know, because of this oversight the United States has one of the most safe—if not the safest—air control systems in the world today.

How would it be if our banking system did not have a regulatory framework? How would it be if we simply threw the entire system of highways open to the private sector and let them design roads for whatever purposes they deemed appropriate?

That is all we are saying, that we want that some framework, some standards and safeguards in our health care system. I think everyone recognizes the need for standards. To say that our banking system, our air traffic control system, our highway system is entirely run by the Government would be a gross exaggeration and an overstatement. The same is true when others characterize the Mitchell bill as a system run by the Government. So I hope we could properly characterize the Mitchell plan and recognize that we must have the kind of oversight and framework that we have been able to acquire in other sectors of our economy. I certainly hope, ultimately, when we pass the legislation that I know we can pass in the coming weeks, that it will recognize the importance of a private sector system in an appropriate governmental framework.

There are a number of provisions that we all indicate are important to us. We have heard speeches on both sides of the aisle about the importance of uniform coverage. We have heard statements about the importance of effective cost control. We have heard many statements from Members of both sides of the aisle that if indeed we do anything, we have to ensure that there be market reforms.

Finally I think I have heard Members on both sides of the aisle repeat with some frequency how important it is that we give the American people the same opportunities for coverage that we have in Congress. Those are statements made, I think, with similar frequency on both sides of the aisle. But when you really begin to compare what is offered by the Republican leader and what is offered by the majority leader, you begin to see there is a difference between rhetoric and fact, between statements of intent and the actual creation of a mechanism to accomplish what we say we all want.

So I would like to spend a little time this morning talking about the way both bills address those things that we feel are critical to meaningful health reform. When I say "we," I am talking about Members on both sides of the aisle, Republicans and Democrats, who acknowledge the importance of universal coverage, effective cost containment, who acknowledge the importance of meaningful insurance reforms, and access to a health system that we as Members of Congress take for granted.

Universal coverage, I think, is an important beginning. Universal coverage has certainly been the subject of a great deal of analysis and discussion and consideration for many years. The Clinton administration made universal coverage its No. 1 goal. Senator MITCHELL, the majority leader, has indicated that his bill would put us on the road to universal coverage by a date certain, reaching at least 95 percent coverage by the year 2000.

The Dole bill, as I indicated last week, is just beginning to be better understood. We have not had a chance to look at all of its provisions in great detail and subject it to the analysis of CBO, which will be performed at some point.

But we do know this: We do know that the Dole plan leaves millions of Americans uninsured. On that fundamental goal that we deem so critical, according to a Lewin-VHI analysis, the Dole proposal leaves out three out of four uninsured Americans by the year 2000. So, 75 percent of those who are uninsured today will be uninsured under the Dole bill in the year 2000—6 years from now. More than 6 million children will still be uninsured under the Dole bill at the end of the decade. Congress is not even required to consider recommendations for achieving the goal of universal coverage.

Madam President, if we enacted the Dole bill today, 30 million Americans would still not have health insurance 6 years from now. That is one of the biggest differences between the Dole bill and the Mitchell bill. Not only are we reversing the downward trend of insured Americans today under the Mitchell bill, going from 85 percent to 83 percent just in the last 2 years—the Mitchell bill would reverse that trend. According to the Congressional Budget Office, health insurance coverage would jump from 83 percent in 1994 to at least 95 percent by the year 2000. Attaining universal coverage, our most fundamental goal, is one of the real differences between the Dole and the Mitchell bills.

So what is the implication to that? It is not just an egalitarian motive. It is not just important we provide coverage to everybody simply because it is the right thing to do. What expert after expert has reported to the Congress, what Lewin-VHI has indicated in their reports to the Congress, is that if we fail to achieve universal coverage, the extraordinary problem of cost shifting will continue. An individual who is uninsured today will is most likely to get care in most expensive setting possible, in an emergency room. Despite their lack of insurance, the hospital will still provide care to them. However, the hospital will shift these uncompensated costs onto others. These uncompensated care costs will be shifted onto the insurance companies, shifted onto individuals, shifted onto businesses, shifted onto the Government. Everybody but that individual receiving the services will be required to pay something for the costs associated with uncompensated care provided in the emergency room or any other setting. This cost shifting has increased premiums by as much as 30 percent. Under the Dole bill, since it does not achieve universal coverage, cost shifting will continue.

So we have a very fundamental difference of opinion with regard to what ought to be the ultimate goal of meaningful health reform. The Mitchell bill, quite simply, says let us achieve 95 percent coverage in the next 6 years. And let us get onto the road to universal coverage sometime shortly after that. And let us end the very serious problem of cost shifting by achieving universal coverage.

The Dole bill says that achieving universal coverage is something we just cannot do. The best we can do is try to insure one out of every four Americans over the next 6 years, leaving three out of those four who are uninsured, still uninsured even in the year 2000.

So I think that is something everyone ought to fully appreciate as we are beginning to analyze how we compare and contrast the Dole and Mitchell bills in the coming days.

The second issue has to do with cost containment. If there is another very critical point upon which there is vast agreement in the speeches on either side of the aisle, it is that we must have effective cost containment. It is no secret that costs have skyrocketed over the last several years. We are now at 14 percent of GDP: CBO says if we do nothing we could reach 20 percent of GDP in the next 6 years. So clearly cost containment is something that we all recognize is critical to meaningful health reform.

Universal coverage is essential to cost control. You cannot really have one without the other. You cannot have meaningful cost containment if you leave a lot of people uninsured and out of the system because, again, cost shifting is going to drive up costs, both administrative and direct costs.

There is no cost containment anywhere to be found in the Dole bill as it is currently written. And for that reason alone, I think you could call the Dole bill the Insurance Industry Protection Act. Furthermore, the market reforms in Senator Dole's bill are riddled with loopholes and fine print and will not encourage competition on price and quality.

Many people have indicated the Mitchell bill is 1,400 pages; the Dole is about 700 pages. I think I happen to have both of them right here with me. It is half as thick because it does half as much. It does little, if anything, on universal coverage, and it does virtually nothing when it comes to cost containment. Cost shifting, as I indicated, has cost businesses more than $40 billion more per year than they ought to be paying—that $40 billion could be going into higher salaries, more profits, greater dividends for shareholders—$40 billion that makes us completely uncompetitive when it comes to our international competition.

There needs to be a recognition that cost-shifting costs the individual family 15 to 20 percent more in higher premiums to cover the uninsured. So without any doubt, employers are paying the price today for those without coverage. The free-rider competitors that are not required to contribute to health insurance are the ones shifting the costs of their employees coverage onto businesses that do not provide insurance.

If we do not have meaningful cost containment, if we do not have a way to ensure that businesses can control their health costs, then I have to tell you, Madam President, I think we will have failed as a country—we certainly will have failed in the U.S. Senate—to respond to those businesses who have made it very clear to us, that, while they want universal coverage, they also need more confidence they can control their future health care costs.

A family in 1998 making between $30,000 and $40,000 would pay $713 more in a nonuniversial system than with universal coverage, according to Lewin VHI.

So businesses and families beware, if we pass health insurance reform without effective cost containment, costs will continue to rise. That, Madam President, will be a tragedy not only for those families and businesses, but for the economy, for competitiveness, and for health security.

We should recognize that the Dole bill is substantially different when it comes to cost containment than the Mitchell bill. Time after time, we have heard on the other side of the aisle how the Mitchell bill fails to achieve the goals the Clinton administration has set out. Let me tell you, there is no comparison between the Dole bill and the Mitchell bill when it comes to cost containment. In the Dole bill, there simply is no cost containment. Everyone should recognize this as we deal with this issue over the next several days.

The third issue that we have discussed at some length has to do with insurance market reforms, and the fact that if, indeed, we are going to build upon the current system, we must recognize some of the inadequacies of the current system. Many insurance reforms have been proposed over the years.

But the Dole Insurance Industry Protection Act, leaves out many of these reforms. The Senator from Oklahoma earlier had made a point about the fact that both Dole and Mitchell eliminate preexisting condition exclusions. In fact, the Dole bill does not eliminate preexisting condition exclusions. They are still allowed.

Anyone who has had the chance to read the bill carefully will be concerned about the coverage that one is allowed to acquire if they lose their job, if they move to another State, if there is a change in their personal circumstances. There is no guarantee of portability, Madam President, in the Dole bill.

Third, the Dole bill contains, in effect, a 15-percent premium tax. It allows insurance companies to charge up to 15 percent in administrative cost to anybody who is in the community-rated pool; 15 percent over and above the standard premium.

Fourth, access to an FEHBP plan—something we say ought to be available to all Americans—is limited.

And fifth, there is absolutely no guarantee of choice. In fact, under the Dole plan, you may not even have a fee-for-service plan available to you.

I want to talk briefly about all five of those points, if I can, because I think they are very noteworthy and, again, a significant departure from what the Mitchell bill attempts to do.

As I said at the beginning of my discussion with regard to market reform, perhaps the only issue about which there is no disagreement, that we ought to do as much as we can to eliminate preexisting condition exclusions. The preexisting condition exclusion, precludes someone with any medical condition or disability from obtaining coverage for that condition—if they have heart disease, if they have cancer, if they have diabetes, if they have any one of a number of diseases today, often they cannot get insurance.

If they acquire those diseases after they have insurance, chances are at some point in the process, they will be dropped. As was indicated, there probably are differences with regard to how we would interpret preexisting conditions, but there is no difference at all in the stated determination on both sides of the aisle to eliminate preexisting condition exclusions. And yet if you look at the Dole bill, in spite of its stated intentions, coverage can be denied up to 12 months for individuals with preexisting conditions and 6 months for those purchasing coverage in a group. While the Mitchell bill phases out preexisting conditions entirely with universal coverage, during the transition period, the exclusion is only for 6 months.

Let me try to contrast the Mitchell and the Dole bills on this point.

Under the Mitchell bill, there is a 6-month exclusion allowed initially but it is phased out entirely over a 6-year period of time. Under the Dole bill, a 12-month exclusion is allowed for an indefinite period of time. So 10, 15, or 20 years from now, if you have a preexisting condition, you may be excluded from your insurance company's policy for whatever preexisting condition you may have.

What kind of coverage is that? What kind of protection, what kind of security, what kind of guarantee are we providing the American people if after 10 years, a preexisting condition can still preclude you from getting the kind of care that you ought to have?

Clearly, there is a significant difference between the Mitchell and the Dole bills when it comes to insurance market reforms, specifically regarding preexisting conditions.

The Dole bill also contains exceptions to portability. Senator DOLE's bill allows insurance plans to enroll individuals and firms on a first-come-first-served basis. Insurance companies and their agents can, therefore, control who they will insure. They may want to insure only a white collar group in the middle of a city. They may not be interested in insuring farmers or an agricultural co-op in South Dakota. Under the Dole bill, they will have that right to preselect, to enroll people that they might prefer to have in their plan, leaving vulnerable those who cannot enroll.

Madam President, the Mitchell bill does something entirely different in this regard. It guarantees everyone an equal opportunity to enroll in the plan of their choice, regardless of what point during the open enrollment period they sign up for coverage. The insurance plan must take everybody up to its capacity. If you want to enroll in Blue Cross/Blue Shield, that is your right. If you want to enroll in some other plan, that is your right.

So we talk a lot about the importance of having choice of plans and providers, but there is a substantial difference between what the Mitchell bill will do with regard to the opportunity for individuals to enroll in the plan of their choice and what the Dole bill does in this regard.

I mentioned another aspect of market reform, Madam President, the fact that the Dole bill includes a 15-percent insurance company premium tax. The Senator from Oklahoma talked a good deal about taxes in the Mitchell bill. I wish I had time to go through a clarification of many of those taxes he pointed to.

The Mitchell bill does say there will be a 25-percent tax, only on those plans whose premium increases exceed a target rate. That is, if a plan exceeds the CPI plus a certain percentage, there is an automatic mechanism to contain those costs in the future by levying an assessment on those plans. There is nothing like that in the Dole bill. If an insurance company wants to charge policy holders 15 or 20 percent in additional premiums, that is their right. There is nothing in the Dole bill to control insurance company premiums. There is no commitment to restrain growth in a given year.

The Dole plan says, "Go ahead, insurance companies, continue to increase your premiums at 15 or 20 percent; we're not going to stop you."

But we are going to let you charge 15 percent above your base premium for community-rated plans—we will allow a 15-percent administrative charge to be tacked on to all insurance plans.

Mr. WALLOP. Will the Senator yield for a question?

Mr. DASCHLE. I will be happy to yield at the end of my statement. I note that the Senator from Oklahoma preferred to continue with his statement, so I will do that, and I would be happy to open it up to the distinguished Senator from Wyoming if he so chooses afterward.

The fourth point that I make, Madam President, has to do with access to FEHBP, the Federal Employee Health Benefits Plan. The Dole bill does not provide everyone access to FEHBP, in spite of the fact we all have indicated that that is something we ought to provide. We talk about the importance of giving the American people the same coverage we have, and I think that is a fundamental difference, between what the Republicans have proposed and what we are proposing.

Under the Dole plan, the only people that would be allowed access to the FEHBP are those who are working for an employer who chooses an FEHB Plan. But there is a further constraint in order to be eligible for FEHBP. You must work for an employer with fewer than 50 workers. If you work for any employer with more than 51 workers, you are out of luck.

In spite of all the recognition of the importance of having access to the Federal Employee Health Benefits Plan, under the Dole bill any employer with more than 51 people is automatically excluded from FEHBP. And that is not the only constraint. Outside enrollment is limited to 5 percent of the health plan's overall FEHBP enrollment. If the Dole bill were to pass, FEHBP would be available only to 5 percent more individuals.

On top of that, the Dole bill suggests that people who are not Members of Congress or employees of the Federal Government would pay a 15-percent surcharge for enrollment in FEHBP. Apparently what we are saying is it is OK for us to have discounted premiums, but if you are going to enroll in the same plans that Members of Congress have, you may have to pay 15 percent more. You can be a worker with a limited income, working for a small businessman who for the first time may be offering insurance. You can have the same access to the plan we have if your employer chooses to give you access to an FEHB Plan, but if you go through all these hoops and hurdles, you still have to pay 15 percent more than what Members of Congress pay for the same coverage. That is the Dole provision on FEHBP.

Finally, under market reform, Madam President, let me touch on another matter that I think is very important. We have heard a lot of discussion about choice—choice of doctor and choice of health plan. Under the Dole bill, cooperatives and employers are not required to offer a choice of plans or a choice of doctor. They may offer their employees plans that do not include a fee-for-service plan. Employers do not have to make available a fee-for-service plan. You can offer anything you want. So if your employer decides to go for the least-cost plan, he may sign you up with an HMO, a PPO, or a plan with very limited options, and if you are the employee, you have

to take that policy, or you do not take anything at all.

Where is the choice? We talk a lot about choice just as we talk a lot about universal coverage and cost containment and market reform. But where is the choice if an employer today can deny you the same choices that the Mitchell bill, the Clinton original bill, and all of those plans have said is so critical to meaningful health reform? Where is the choice when an employer can cut you out of a fee-for-service plan, and can restrict your choice of doctor? There is no choice, and that is something I hope will be well understood as we compare and contrast the Mitchell and the Dole bills.

The next point that I think has been made in the past but is worth repeating is the importance of cost when it comes to the working families.

I have a chart that outlines the average cost of a plan in terms of percent of income under the Mitchell bill. Under the Mitchell bill, if you have an income of $22,172—that is about 150 percent of poverty—your payment would be $1,471, which is about 6.6 percent of family income. Under the Dole plan, the average premium would be $5,883, or 26.5 percent of family income. That is the difference, Madam President. A working family of four with a reasonable income of $22,000 will pay 6 percent of their income under the Mitchell plan, and 26 percent under the Dole plan.

If you look at the impact on children, the situation is even more stark. Under the Mitchell bill, that same family with a $22,000 income, at 150 percent of poverty, would pay no premium to cover two children. Under the Dole plan, a family with children would pay 26.5 percent of their income in premiums.

As we go through these calculations, it becomes clear the Dole plan is an expensive plan. The Dole plan not only does not cover everybody, but costs will be very high for those it does cover.

Madam President, a question was raised today about why seniors would support the Mitchell bill and not the Dole bill.

I think it is pretty obvious why the Mitchell bill enjoys the support of seniors across the country. The Mitchell bill is endorsed by AARP and many individual seniors because it does something for seniors. It recognizes the importance of prescription drug coverage for seniors. It recognizes that more than 18 million Americans over the age of 65 would obtain drug coverage under the Mitchell bill, but would have no coverage under the Dole bill.

The Dole bill does not ensure drug coverage for seniors. It leaves seniors completely out in the cold.

It is not just seniors who are left out. I mentioned earlier the fact that businesses are going to absorb $30 billion this year to cover the uninsured. We are told by Lewin-VHI, if we do nothing or if we pass the Dole bill, the cost shift on American business today would go from $30 billion to $45 billion by 1998.

That is a substantial increase in the cost that businesses are going to have to absorb simply because there are currently free riders in the system today. Family coverage will still be one-third more expensive in 1998 than it is right now to pay for these free riders. Under the Dole bill, there are no employer discounts, no incentives to provide coverage, no guarantee that we are going to end the cost shifting. Businesses, small and large, are going to continue to absorb the costs that they are absorbing today. They are just going to absorb a whole lot more.

Finally, let me touch on an issue that is very important to the manager of the bill, the chairman of the Finance Committee. We have talked at length about research and work force training. These topics are important not only to the State of New York but to every State. Science is important. Medical research is perhaps the key to our long-term future. We must continue to send the message, not only to those in our country but around the world, that we are going to invest in technological innovation and medical research in a way that gives us the ability to respond to the medical problems that we have in the country today.

Under the Dole bill, there is no additional Federal money for research or work force training. Under the Dole bill, the only additional NIH research funding would be funded through a voluntary $1 tax return add-on. This is another reason why the Dole bill is slimmer than the Mitchell bill. The Dole bill leaves out research.

(Mr. BYRD assumed the chair.)

Mr. DASCHLE. Under the Dole bill, public support for academic health centers is reduced without any increase in coverage or funding to offset the loss from the reduced ability to cover costs from the private sector.

Mr. President, I hope that as we go through the coming days we will have the opportunity to compare the Dole and Mitchell bills, and that we will have the opportunity to prove that the Mitchell bill is a thicker bill because it simply does more. In fact, I believe it does more than twice what the Dole bill does. I hope that throughout the day today we will have opportunities to revisit many of these issues again.

I yield the floor.

Mr. WALLOP addressed the Chair.

The PRESIDENT pro tempore. The Senator from Wyoming.

Mr. WALLOP. Mr. President, I am about to yield to the Senator from Texas 3 minutes. But let me say to my friend that I do not know why anybody is talking about the Dole bill a lot of us have cosponsored. It has more cosponsors than any other bill around. But the fact of it is that we are not to be allowed to debate it or discuss it because we are not to be allowed to have CBO's estimate on it. We are not to be allowed because it is taking place behind the House's need for CBO's estimate. We have the CBO estimate on the Clinton-Mitchell bill. But we are not to be allowed. So whatever you say about the Dole bill may or may not be true. I suggest that I quarrel with most of what the Senator said. But the fact of it is, it is irrelevant because we are not to allowed to have that as a part of the debate.

The PRESIDENT pro tempore. The Senator from Texas [Mr. GRAMM] is recognized for 3 minutes.

Mr. GRAMM. Mr. President, in listening to our colleague from South Dakota, I am stunned that anybody could be against the Mitchell bill and be for the Dole bill. Listen to what our colleague said. He said if you are making $22,000 a year, under the Dole bill you will have to pay 26 percent of your insurance premiums. Somebody else is going to pay the rest of it. Under the Mitchell bill, you are only going to pay 6 percent, and somebody else is going to pay the other 94 percent.

Our dear colleague from South Dakota said that under the Mitchell bill, we are going to give $96 billion of new benefits to our senior citizens. How could anybody listening to those wonderful numbers be for the Dole approach and not be for the Mitchell approach? There is only one reason, and the reason is that the Mitchell bill cost $1.1 trillion over a 10-year period.

In 1950, the average American family with two children sent $1 out of every $50 it earned to Washington, DC. Today, that same family sends $1 out of every $4 it earns to Washington, DC, and under the Mitchell bill, in 10 years that family would send $1 out of every $3 it earns to Washington, DC.

So there is only one reason that someone would not think it is such a great and wonderful idea for the Government to give all of these benefits away. And the reason is the Government is broke. The reason is that when somebody gets something for nothing from the Federal Government, some working person somewhere gets nothing for something. Who is paying for all of these great subsidies? Who is picking up the cost of the other 94 percent of the cost of health insurance under the Mitchell bill? The taxpayer. Who is picking up the tab for all of these new and wonderful benefits that we all wish the Lord had simply provided? They probably were provided in the Garden of Eden. But having arrived in the state we are currently in, ultimately the only way we can give things away is to take them from other people.

There are literally tens of millions of Americans who believe that we have already taken away too much from the

people who do the work, pay the taxes, and pull the wagon in America and that this process has to stop.

The big difference between the Dole bill and the Mitchell bill is that the Dole bill seeks to reform health care by promoting a more efficient system. The Dole bill will help working people by paying part of their premiums, not as much as the Mitchell bill—but without the 18 new taxes found in the Mitchell bill. The Mitchell bill has 40 new Government regulatory agencies, and over 100 unfunded mandates.

It is a miracle what you can do with $1.1 trillion, which is what the Mitchell bill would spend in a decade. There are only two problems, however. No. 1, it is not our money. No. 2, the only way we can get the money is by reaching into the pockets of the working men and women of America and taking it away.

So if all you want is more Government, then you are for the Mitchell bill because it gives you more Government, and it gives you more Government in a greater abundance than any other bill ever considered in the history of the United States of America.

The problem is that the American people do not want all of this Government. That is why the Mitchell bill is losing, why the Gephardt bill is losing, and why the Clinton bill has lost. The sooner we stop talking about all of the free things that are given away and start talking about how we are going to pay for them, the sooner we might actually be able to write a bill that would meet the needs, not just of all the people riding in the wagon, but meet the needs of the people pulling the wagon.

I yield the floor.

Mr. PACKWOOD addressed the Chair.

The PRESIDENT pro tempore. The Senator from Oregon, [Mr. PACKWOOD].

Mr. PACKWOOD. Mr. President, I believe the Senator from South Dakota has a statement. Are we under controlled time?

The PRESIDENT pro tempore. We are not under controlled time. The time is equally divided.

Mr. REID. Parliamentary inquiry, Mr. President.

The PRESIDENT pro tempore. The Senator does not have the floor.

Mr. PACKWOOD. I yield such time as the Senator from South Dakota may need.

The PRESIDENT pro tempore. Does the Senator from Oregon yield for a parliamentary inquiry to the Senator from Nevada?

Mr. PACKWOOD. Yes.

Mr. REID. Parliamentary inquiry, Mr. President.

The PRESIDENT pro tempore. The Senator will state the parliamentary inquiry.

Mr. REID. I was told by the manager of the bill on this side that we would go side to side, and that I would have time during today. That being the case, the Senator from Texas just completed his statement.

The PRESIDENT pro tempore. The Chair is not aware of any such provision in the unanimous-consent agreement.

Mr. PACKWOOD. I wonder if I might solve it in this fashion. I apologize to the Senator from Nevada. Senator GRAMM indicated that he wanted to respond to a point raised by Senator DASCHLE. When we were debating this last week, we went to one side and then to the other. I would appreciate it because the Senator from South Dakota has been waiting and was scheduled to go—his statement is not a long statement—if he could do it. Senator GRAMM says he spoke 2 minutes 20 seconds.

So I would very much appreciate it if the Senator from Nevada would indulge us. I apologize if that agreement was made. But Senator PRESSLER was from our standpoint scheduled to go next.

Mr. MOYNIHAN. Mr. President, I am sure we can work this out. Senator GRAMM's intervention was in the way of a response to a specific point that had been made by the previous speaker. I had fully expected that there would be a proper address on this side, and at the conclusion of which the Senator from Nevada will have as much time as he would like.

Mr. PACKWOOD. I thank the chairman. I thank very much the Senator from Nevada. I yield such time as the Senator from South Dakota may need.

The PRESIDENT pro tempore. It is the Chair's understanding now that no order has been entered for alternate recognition.

Mr. MOYNIHAN. Mr. President, I do not know that this would be necessary. I believe that as the respective managers we have worked this out on the basis of comity. It may be that a time will come when no speaker appears on one side and the attendance is not excessive, as is evidenced by the graciousness of the President pro tempore to preside. We do not request that.

The PRESIDENT pro tempore. The Chair understands. The Chair will have to make it clear that the Chair will accord recognition on the basis of the rules, unless an order is entered that there be alternate recognition.

The Senator from South Dakota is recognized.

Mr. PRESSLER. Mr. President, let me begin by saying that I welcome the debate which will occur over the next few weeks. It will be a spirited debate, and it will force us to take a stand on difficult issues. It also will require us to stop the rhetoric and begin voting. As we debate, we must not overlook one simple fact: Health care reform will literally affect every man, woman, and child in this country. We need to proceed with extreme caution. Our decisions will impact all of our constituents.

We all agree that our health care and health insurance systems need some reforming. Our differences are not about whether we need reform. Rather, this debate is about how best to reform those systems. The health care debate really boils down to one simple question: How much Federal Government do we want in our health care system?

Medicine is defined as the study, treatment, and prevention of disease. Our medical system is one of the best in the world. In 1920, the average life expectancy of an American was 54 years. Today, that has climbed to 75. In 1920, the 10 most serious diseases were tuberculosis, influenza, pneumonia, nephritis, sclerosis, cephalitis, diphtheria, whooping cough, measles, and gastritis.

Today, vaccines and medications have greatly reduced the occurrence of these disorders. Over one-half of all medical technology—the life-saving machines, treatments, and medications that make our system great—have been developed in the United States. Over 90 percent of our medical technology is developed in the private sector.

Despite its flaws, our medical system is the best in the world. It does work. Our system has enabled us to live longer and more productive lives. Change for change's sake must not be permitted to jeopardize this achievement.

The primary focus of the health care debate has been on those Americans who do not have health insurance. We need to help them. This can best be done, in my judgment, through insurance reforms and subsidies. However, the health care debate has failed to focus on those Americans who do have health insurance. An estimated 85 percent of Americans have health insurance. We cannot forget them in this debate. We must not jeopardize the health care of these individuals.

A poll conducted by a newspaper in my State indicated that 80 percent of all South Dakotans were satisfied with their health insurance. Poll after poll confirms that most Americans are satisfied with their health insurance. Consequently, I ask, why do some advocate a radical overhaul of the entire health care system?

Do Americans desire to pay less for their health care? Of course. Can steps be taken which will reduce medical costs? Of course.

Do Americans want some changes? Yes, they do. However, they do not want reform just for the sake of reform.

Mr. President, my point is this: We need to listen to all Americans. They are telling us to proceed with caution and to fix only the broken elements of the system. South Dakotans are letting me know how they feel. My office has been receiving over 100 calls and letters each day on this issue. Between

the time the President introduced his health plan last fall and April 1 of this year, over 19,000 South Dakotans contacted me to express opposition to all or part of President Clinton's health plan. The message is clear—South Dakotans do not want a Government-controlled health care system.

I normally do not find myself quoting newspaper editorials. However, several papers in my home State have printed editorials that reflect the sentiments of South Dakotans. The Mitchell Daily Republic gives this advice:

There's no question that changes in health care are needed. But to change for change's sake would be folly.

Our advice: Slow down. Depoliticize. Do it right the first time.

The Yankton Press and Dakotan writes:

Bulling through "something" that will get a majority vote in Congress may be good politics, but it's bad policy.

The Watertown Public Opinion writes:

Gephardt, Gibbons, and others who favor employer mandates apparently feel the tremendous job losses and reductions in wages are not too high a price to pay for health reform. We suspect most working Americans feel differently * * *.

The Huron Plainsman writes:

There are alternatives on the table that could do some good without starting from scratch—for example, portability of health insurance from job to job, insurance pools for preexisting conditions, and those struck by catastrophic illness * * *.

Mr. President, these articles reflect the views of my constituents.

I ask unanimous consent to insert the full newspaper editorials I have referred to in the RECORD.

There being no objection, the articles were ordered to be printed in the RECORD, as follows:

[From the Daily Republic, Aug. 10, 1994]

BAD HEALTH BILL WORSE THAN NONE

It was one of those sound bites television is known for, which means it's done in a flash, so we apologize for not attributing it.

But in essence, the voice was saying, "Passing a bad health care bill would be worse then passing no bill at all."

We couldn't agree more.

Why are some so eager to rush to judgment on health care? In a word, politics.

There is a theory making the rounds that if President Clinton and the Democrat controlled House and Senate can pass a health bill soon, it will help them during the November elections.

It's no secret that Republicans believe they can make inroads in the Democrat majorities in both houses. Maybe they will. If so, it would not be unusual in an off year election.

But political strategies should be left out of a reform measure that promises to be the most far-reaching legislation since Medicare. The key question should be if a hastily pasted-together health care bill would be good for the public. That's an easy one to answer.

Just the sheer complexities of the proposals are enough to boggle the experts, let alone Congress. And, the differing characteristics of each plan has splintered the support. For instance, the bill proposed by Senate Majority Leader George Mitchell last week, which was a far cry from Clinton's original bill, still has so many negatives that it has failed to attract the needed bipartisan support.

The bill proposed by House Majority Leader Richard Gephardt faces a similar fate. And for good reason. The mandates forced on businesses in the Gephardt proposal could cost thousands of jobs because it forces businesses with more than 100 employees to pay 80 percent of their employees' health insurance.

That aspect alone would run up $58.8 billion in new costs, or about $586 for each employee, according to some analyses.

What is deeply troubling is the mindset that "some" sort of health care plan must be passed this summer or fall. Never mind that no firm dollar figures have been attached to any of the administration's proposals; never mind that an increasing number of Americans are seeing that a blank check for a new federally administered program would be disastrous.

Thre's no question that changes in health care are needed. But to change for change's sake would be folly.

Our advice: Slow down. Depoliticize. Do it right the first time. It will be less costly in dollar and human terms and the end product will be of far better quality.

ANY FEDERAL HEALTH CARE PLAN DESERVES MORE TIME FOR IN-DEPTH STUDIES

Whether Sen. Larry Pressler has the best ideas on health care plans or the worst, the South Dakota Republican's comment recently to reporters on the subject is worth analysis.

Says Pressler, Democrats will try to blame Republicans for blocking health care reform efforts, but it's the Democrats themselves who can't get together on a single plan.

While an analysis by an opposing politician usually is poopooed, this one makes pretty good sense.

So also does Pressler's comment that, "This is a very important bill to South Dakota and the nation. I think we should have time to study it, at least."

Pressler is at least 100 percent right on that.

Whether the reader is absolutely convinced that the country really needs fully socialized medicine, or whether the preference is for no public involvement at any level, Pressler still is right.

There has been, and will continue to be, too much hype on health care.

The major problems have likely been ignored, anyway.

Assuming that "the wheels" are right in their figures that only about 20 percent of Americans aren't covered, and that surveys show that health care is not even a top issue for most of us, one wonders what is driving the health care legislation engine.

It might be that the worst problems are in urban areas where there is the most representation.

It might also be that hospitals and doctors are tired of messing with "charity" patients whose medical bills then must be paid for from inflating the bills of paying customers who have insurance of one sort or another.

It might also be that there are some folks who genuinely believe that socialized medicine, Soviet style, is the only fair way to offer treatment to Americans.

And don't forget the possibility that there are some folks who are looking at the trends, and figure that there is no way on earth for the country to pay for the highest level of medicine when the baby boom hits retirement age.

There are all kinds of disagreements on policy and philosophy to be found in any bill. The situation with various cost-inflation factors—$10 sneeze-tissue boxes, for example—is enough to make the most dedicated right-winger cringe and suggest federal regulation.

Also for example, those who sincerely object to abortion or blood transfusions should have their rights upheld along with those who fervently disagree. That won't be easy.

Anyone studying the question also agrees that, morally distasteful as it may be, there likely will be quotas on treatment and spending that will result in deaths when more treatment might have some slight chance of success.

As this column has said before, there are many deep philosophical questions on medical ethics that the country must generally agree to. Otherwise, no "federal health care program" can succeed.

That's why Pressler is right in suggesting more time to study any bill: Bulling through "something" that will get a majority vote in Congress may be good politics, but it's bad policy.

Bad, politically correct law is still bad law.

HEALTH CARE MANDATES APPEAR TO BE UNHEALTHY

House majority leader Richard Gephardt, D-Mo., is putting the last touches on a health reform bill that he expects to bring to the floor for a vote in the near future. Like so many issues coming out of Washington, the more we read about them the more confusing they become.

However, this much we know about the forthcoming bill: It is a derivative of a measure previously approved by the taxwriting House Ways and Means Committee. It would finance universal coverage of all Americans, primarily by imposing employer mandates.

Like President Clinton's original proposal, Gephardt's bill would require that employers pay 80 percent of workers' health insurance premiums. At the moment, it appears unlikely that a majority of the House will support such a crushing mandate.

Even House Speaker Thomas Foley, D-Wash., has backed away from full-blown support for the most controversial element of the Clinton plan. Recently, he floated the idea of setting the employer mandate at 50 percent with workers picking up the remainder.

But it matters not politically, whether the employer mandate is set at 80 percent or 50 percent. If liberal leaders want to pass a health reform bill this year, if they hope to win any support from conservatives, they must jettison the employer mandate altogether.

Of course, many of the liberal lawmakers continue to insist that employers be forced to pay much of the cost of health reform. The acting chairman of the Ways and Means Committee, Rep. Sam Gibbons, D-Fla., warns that even reducing the employer mandate from 80 percent to 50 percent would require the government to spend an additional $30 billion a year on health care subsidies.

The problem with Gibbons and other advocates of employer mandates is that they have too little appreciation for the dynamics of the American economy. They think they can hit employers with a mandate—essentially an indirect tax, costing upward of $100 billion a year—and that those employers will continue to conduct business as usual.

Of course they won't. If employers are forced to pay an expensive new mandate, they will have to cut costs. The likeliest way of doing that is by lowering the overall wages of their workers or paring altogether from their payrolls those whose productivity does not cover their salary plus the additional cost of their health benefits.

Harvard professor Martin Feldstein, who also presides over the National Bureau of Economic Research, estimates the employer mandate would result in a 6.4 percent reduction in average wages by 1997. That's a $115 billion net loss in worker income. This, in turn, would lead to a loss of $49 billion in tax revenue in 1997 alone, he reports.

Meanwhile, an analysis by the consulting firm of DRI/McGraw Hill estimates job losses stemming from the employer mandate at anywhere from 888,000 to 2.4 million.

Even the Clinton administration has conceded the mandate would eliminate at least 600,000 jobs.

Gephardt, Gibbons and others who favor employer mandates apparently feel the tremendous job losses and reductions in wages are not too high a price to pay for health reform. We suspect most working Americans feel differently. . .

[From the Plainsman, Aug. 9, 1994]

HEALTH-CARE BILL COMES DOWN TO THE WIRE

Eleven months after President Clinton unveiled his health-care reform package to Congress and the nation, the issue he has called the cornerstone of his presidency has all but crumbled.

The reason: The White House and Democrats have seriously misjudged the public's vital signs, while Republicans have forced the debate into a referendum on whether citizens want more government in their lives.

Everday Americans, who have the most at stake with legislation that would nudge medical insurance coverage to 95 percent of the population by 2000, are asking reasonable questions about cost and services. They want to know why government wants a substantial role in running the health-care system, which accounts for one-seventh of the U.S. economy. People naturally are skeptical—a necessary predisposition among those who want to keep their liberty. In fact, two-thirds in a Newsweek poll say it would be better to wait until next year to tackle health-care reform.

In response, the administration has lumped all who have doubted the benefits of the Clinton health care bill as nearly traitors.

This is what Mr. Clinton said over the weekend: "The violent, extremist interests in this country that are trying to keep health care out of the reach of ordinary American working people are a disgrace to the American dream."

Some would say this outburst was frustration borne of a struggle to make life better for citizens.

But why make excuses? It's uncalled for and shifts attention away from the merits of the case for reform.

There are alternatives on the table that could do some good without starting from scratch—for example, portability of health insurance from job to job, insurance pools for pre-existing conditions and those struck by catastrophic illness, and incentives to stay well instead of traipsing to the doctor with every sniffle. On these issues, there is near unanimity, and they are doable and affordable.

Still, some within the administration aren't reading from the same page of the hymnal. "Tinkering around the edges . . . will not work," said Health Secretary Donna Shalala.

Congress has time yet to use politics in the best sense—as the art of the possible. Compromise on health-care reform will serve the interests of most of the public. Congress should stay in Washington until they vote on a plan, and voters will decide in November whether they did too much or too little.

"Our View" is the opinion of the Plainsman's editorial board: Publisher Daryl Beall, Editor Cliff Hadley, Managing Editor Roger Larsen, Associate Editor Dave Harles and Regional Editor Crystal Pugsley.

Mr. PRESSLER. Mr. President, I have held several meetings in recent months on the issue of health care reform. As always, the advice obtained from these meetings is valuable. A comment from one farmer stands out in my mind. He told me a story about a farmer who had 10 pieces of farm equipment. Every spring he would take them out of the barn and get them ready for the spring work. He would overhaul only those machines that needed overhauling. He would just tune up the others. That is how we should proceed on health care reform. Let us fix that which is broken and leave alone the elements that work.

I want to air some of my concerns about the full-court press to pass a health care bill before the American people have adequate time to digest the details. I am not opposed to moving right along. A year ago in April, I said we should start voting on health care reform. In fact, I would like to start voting today, if we could, because we all have about as much information as we are going to get.

I am concerned that political motives are the driving force behind this push. I am concerned that the mission of the Democratic leadership has been to get a health care bill—any health care bill. As I mentioned, in April of 1993, Senator SPECTER and I came to the Senate floor and said, "Where is the bill?" President Clinton had failed to meet his goal of giving us a health care reform proposal within the first 100 days of his administration. Our point was simple: Health care reform had been debated long enough. It was time to start voting in the Senate.

Let me say that it is very ironic that the Senate has not had any real votes on this issue. It seems that the legislative process normally would be that the Finance Committee would pass a bill, which they did, and that bill would come to the floor, and we would have amendments—perhaps an amendment every hour—for several days, and the Senate would work its will. But that is not happening because the majority party's own Members would not vote for the bill. They would lose their own Members on the amendments. So, therefore, we are in the position of negotiating behind the scenes with different bills popping up here and there.

Why do we not start offering amendments and vote every hour, letting the Senate work its will, instead of negotiating behind closed doors?

Well, the reason is, the majority party does not have the votes. If the Mitchell bill were brought up on the floor this afternoon, it would be defeated, not necessarily by Republicans, but by a bipartisan coalition. Indeed, I have read in the papers that Senators from my neighboring rural and small city States have raised serious concerns about the Mitchell bill.

What if we brought a group of political science students to watch the Senate of the United States today, or this week, while we are debating health care reform?

This would be a very strange demonstration of our legislative process for them to witness.

It is the opinion of this Senator that we should have proceeded in the normal way, brought the Finance Committee bill to the floor, began to offer amendments on it, and voted on those amendments with a time agreement of an hour.

This is a very bizarre August situation in which we are staying in session longer, supposedly to pass a bill. But the people in the galleries and the people watching this process do not see any amendments, they do not see any votes being taken. What is going on here? Our side has not filibustered. Why does the Senate not work its will? The reason is because the majority party does not want to vote. They want to maneuver around to a position where they can blame the Republicans if they do not get a bill. It is not a constructive process.

I would much rather be recorded on votes every day than be giving this speech, after which there will be no vote. There will be one vote today, and that is essentially a bed check vote. We are going to be in session next Saturday. We were in session all day last Saturday, and there was not a single vote on anything. But, we are showing the country how hard we are working.

So let us remember who is doing this and how strange it is and how sad it is. This is not the way the Senate and the House are supposed to function.

We may not start voting until September, and then the bill would be brought to the floor in such a way that individual votes would not be allowed on certain issues.

The situation is similar in the House. The Rules Committee prevents the House from voting on a lot of tough issues, and then the bill is put into a big package in which the details are concealed. This is why the public is disgusted with Congress.

In any event, it is ironic that the biggest proponents of the Mitchell plan argue they need more time. They argue the issue is too complex and last year was not the time to vote.

Several weeks ago, the President and the Democratic leadership declared the

Clinton plan dead. They did not take a single vote on it. Why did they not bring it up for a vote?

They did bring the Clinton plan up for a vote over in the Ways and Means Committee in the House, and the majority of the Democrats voted "present" because none of them wanted to vote on record for it. That is what happened.

This is very strange in a democracy, for here in Congress we have all these negotiations going on behind closed doors with no votes. Let us face the facts. The Democratic Party controls the House, the Senate, and the White House. They can start votes any time they wish. I wish they would.

The Democratic leadership indicated they were taking a new approach to reform. This would be less bureaucratic and less confusing than the President's plan, we were told. The legislation we are debating now was unveiled a week ago. It is some 1,410 pages and weighs 14 pounds. No hearings have been held on this proposal. The American people do not know what is in the bill. Things have not changed. It calls for more Big Government and higher taxes. And the American people are not being told these facts.

President and Mrs. Clinton should be commended for their role in bringing the health care issue to the national forefront. In fact, the First Lady was in Lennox, SD, last February. She is impressive. She understands the issues. She listened tirelessly to hundreds of South Dakotans discuss the shortcomings of our current system, although I must say that the Clintons' exact proposals for changing it were not very clear.

The portions I have read of the Clinton-Mitchell bill convince me that it is bad medicine for South Dakota. It will hurt my State. Apparently the Democratic Senators from Oklahoma, Nebraska, and North Dakota have decided the same thing, as I as a Republican have decided, because they have raised serious concerns about the Clinton-Mitchell bill.

Does this mean that I oppose reform? No. Does this mean that every provision in the Clinton-Mitchell bill is flawed? Of course not. However, in totality, the Clinton-Mitchell bill is the reconstituted Clinton plan, which would result in more taxes, more bureaucracy, more government and lost jobs.

The bill is bad for South Dakotans for several reasons, including:

More government.

The Clinton-Mitchell bill would result in the creation of at least 50 new Government agencies and offices. The Multinational Business Services, Inc., completed a study of the original Clinton bill. This group concluded that the President's plan would result in the creation of 98,000 new bureaucrats, 59 new Government offices, and 4,348 pages of new Federal regulation.

Proponents of the Clinton-Mitchell bill claim that the new plan is less bureaucratic. Do not be fooled. It would create more Government bureaucracy.

More Taxes.

The Clinton-Mitchell bill includes 17 new taxes. Some examples include: a 1.75-percent tax on all health insurance premiums, a 25-percent tax on all high cost premium plans, and a requirement to force all State and local government officials to pay Medicare taxes. No one would be exempt from these taxes.

Rural areas.

The Clinton-Mitchell bill would hurt small cities and rural areas.

Why? The plan would cut Medicare by $278 billion over the next 10 years. The bill indicates this on page 723. South Dakota hospitals, particularly those in rural areas, are dependent on Medicare for their survival. Cuts of this magnitude would force hospitals to close.

The Clinton-Mitchell bill does not allow the self-employed to deduct the full cost of their health insurance premiums. Truckers, farmers, and ranchers tell me the best tool to help them purchase insurance is to make their insurance premiums tax deductible.

Finally, the Clinton-Mitchell bill does not allow individuals to set up medical savings accounts.

Employer mandate.

Regarding the employer mandate, any requirement mandating employers to pay the medical insurance costs of their employees would result in lost wages and lost jobs.

A study by the American Legislative Exchange Council projected 2,900 South Dakota jobs would be lost if the Clinton employer mandate were implemented.

Another study indicates that 52,545 South Dakotans would experience annual wage reductions of $1,200 for a family of four.

Standard benefits package.

All Americans would be required to obtain an identical benefits package. This package includes abortions.

There are many Americans, both pro- and anti-abortion, who do not want the Government to set up abortion clinics. They do not want taxpayer dollars to fund abortions on demand, which is essentially what the Clinton-Mitchell bill provides for. There are many people who are pro-choice who disagree with this massive new Government abortion program. We should consider this viewpoint.

More entitlements.

Under the Clinton-Mitchell proposal, some 100 million Americans, families and individuals with incomes under $35,520 or 240 percent of the poverty level, would be eligible for a subsidy to help pay for their health insurance. One out of every 2.5 Americans would receive a Federal subsidy.

In short, the Mitchell bill and the Clinton plan from which it is derived, is too costly, too bureaucratic, and will increase taxes.

We need to make some changes in our health care system. We do not need to overhaul the entire system. We need to fix what is broken.

Now let me say what I am for. I did not get elected to the Senate just to oppose things. I am for a positive program. In any event, the health care reform should include:

Universal access to health insurance;

Insurance reforms, including insurance coverage that cannot be canceled;

No denial of coverage for preexisting conditions;

Voluntary purchasing pools;

Revision of medical malpractice laws, including caps on attorneys fees and a $250,000 limit on noneconomic damages;

Abolition of unnecessary paperwork;

Reduction of Federal regulations;

Modification of antitrust laws;

Subsidies to help the poor purchase private insurance;

Establishment of medical saving accounts; and

Full tax deduction of medical costs, including insurance premiums, for the self-employed.

Mr. President, the health care reform legislation we are considering is extremely complex. We would be well-advised to be careful in writing this bill. As everyone should know by now, we are talking about one-seventh of our economy.

If we are at all unsure about the consequences of our votes on the cost an quality of health care, we owe it to the people to vote no or, at least postpone making certain decisions until more information is available to us. It is within our power to recognize and act upon those specific problems about which all of us agree.

We can have a bill that fixes those commonly recognized problems. We can set aside what is now caught up in extreme controversial—mandates new bureaucracies, and higher taxes.

In conclusion, Mr. President, let me say that this Senator believes the Senate should proceed the old fashioned way. We should have taken the Finance Committee bill, brought it to the floor, offered amendments and voted on it.

This Senator would not object to a vote every half-hour, with 15 minutes equally divided, so that the Senate can work its will. This Senator thinks it is very strange that the Senate and the House are proceeding in this manner.

I want to legislate. For a year, since last April, I have said, let us bring legislation to the floor and the Senate will vote. That is what we are supposed to do. That is my judgment.

Let me also say that we have the best health care delivery system in the world. I think it needs some reform, some fixing, some tuning up, but let us not throw the baby out with the bath. Let us proceed to come up with a bill

that will solve the problems without hurting the main body of our health care system.

But let us begin to vote. Let us begin to legislate. That is what Senator SPECTER and I said on the floor a year ago in April. This Senator is ready to go.

Mr. President, I yield the floor.

Mr. MOYNIHAN addressed the Chair.

The PRESIDENT pro tempore. The Senator from New York [Mr. MOYNIHAN].

Mr. MOYNIHAN. Mr. President, may I offer my congratulations to the Senator from South Dakota for his statement that it is time to start voting. And may he have much influence on that side of the aisle, which I know he does, although it may not be on this particular point. But we are in complete accord.

Mr. President, I have the great pleasure to yield to my friend, the learned Senator from Nevada, as much time as he may require.

The PRESIDENT pro tempore. The Senator from Nevada [Mr. REID] is recognized for such time as he may require.

Mr. REID. Mr. President, you and other Members of this body were present today when the majority leader pointed to his desk and he said, "No matter how many times you call this desk a horse, it will never become a horse. Even though if you repeat it often enough, there will be some who believe this desk that stands in front of me now would be a horse, it is not. It is a desk. It is a wooden desk."

I say to my friend, through the Chair, the senior Senator from South Dakota, that he should check with the leadership on that side of the aisle. We are ready to vote. We have an amendment that is now pending to this legislation.

But I sat on this floor Saturday and Friday and heard the distinguished minority leader say, "We need more time. We have only had 11 or 14 Senators on our side that have been able to make statements about the bill. Therefore, go slowly."

In fact, one Senator stated he was not ready to proceed at this time. He needed more time to study it. And it was at that time that the dialog on the Senate floor came that there had been some 85 hearings on health care on this side of the Capitol; reams of reports.

We are ready to go forward, Mr. President. I have some amendments that I would like to offer. There are others that would like to offer some amendments to the bill that is pending before this body.

I also say that I disagree with my friend from South Dakota. I think a political science class from high school, college level, whatever level, would be very instructive for students to come to this body today, tomorrow, or had they been here last week. This is what our country is all about. The legislative process is the art of compromise.

We are trying to work out legislation based upon a bill reported out by the Labor Committee and a bill reported out by the Finance Committee. The majority leader has taken what he feels is the best of both bills. He has taken what he feels is the best of the Clinton proposal. He has been working with the House leadership and he has given us a bill, something that you can look to and read about.

That is much different than I hear on that side of the aisle. We have people on that side of the aisle stand up and say, as they have—not all of them, but most of them—"We want a bill that contains costs, that allows portability, that would not prohibit insurance being offered as a result of a preexisting condition," and all these buzz words. But where is the legislation?

What they have now, the bill offered by the Senator from Kansas, the minority leader, does not cover that, does not take care of that. So where is this ideal piece of legislation that they want?

And again, I refer, Mr. President, back to the majority leader. This is a desk. This is not a horse. And no matter how many times you say it is a horse it is not going to be a horse.

On the other side, one of my friends who I work with, the junior Senator from Oklahoma, I serve with him on the Appropriations Committee, work with him on the Interior Subcommittee; I have great respect for his ability. However, his saying that we do not have medical malpractice reform in the Mitchell proposal means that he has not read the bill or that staff has not advised him of what is in this bill.

Again, this Mitchell proposal relating to medical malpractice insurance does the possible, not the impossible. They can talk all they want about the ultimate in medical malpractice reform, but what we have in this bill on page 1,037 is medical malpractice reform.

Mr. President, I know a little bit about medical malpractice litigation. Before I came here, I did quite a bit of it. I defended doctors and I prosecuted claims for people that were injured.

This is pretty good reform; not the ultimate, but pretty good reform. It sets up a program. First of all, it limits contingent fees. People say, "What is that?" It is a lot. It limits contingent fees to one-third of a claim up to $150,000 and anything over that is 25 percent.

The reason that is important, in Nevada—and we are not different than a lot of States—in Nevada sometimes attorneys took 50 percent contingent fees; 40 percent on a medical malpractice case was not unusual at all. So this is significant reform.

It also set up, Mr. President, every State, it is mandated under the Mitchell bill that they set on a State basis, because one of the things we do not want to do in this area of the law is take away States' rights.

What this does is mandate in a State that they set up an alternate dispute system for medical malpractice cases. It does not tell them what they have to do, but that they set it up. And before you can prosecute a case, you have to file a certificate saying you have been attempting to comply with that.

I am not going to go into all that is in here with regard to medical malpractice. But it is significant reform. And no matter how many times on the other side of the aisle they say there is no medical malpractice reform does not mean it is true, because it is not true. There is medical malpractice reform

Mr. President, I have heard a number of people say today that we have the greatest health care delivery system in the world; what we need to do is tinker with the edges, refine it a little bit.

I acknowledge we have a great health care delivery system in this country. But it is in trouble because it is bankrupting us.

The State of Nevada has had to call two special sessions of the legislature because of escalating health care costs.

What is driving the deficit on the national level? Health care costs. So, we have to do something about it.

This year, Mr. President, health care costs in America will go up over $100 billion—not $100 million. This year, 1994, health care costs in our country will go up over $100 billion, and we will not have better health care as a result of that. It is going to bureaucratic redtape, Government and insurance company red-tape, and fraud, waste, and abuse. The Mitchell bill goes to the heart of that. The Mitchell bill will not cut out all the waste, fraud and abuse, but it will get to a big chunk of it. It will significantly damage those who like redtape.

It does a great deal. For example, I have heard a couple of people on the other side of the aisle complain about commissions being set up. It was interesting to see, from the first speaker to the second speaker, the number of commissions dropped by 28—not by 28 percent, by 28. They went from 48 to 20.

But regardless of that, we could look at each one of them, recognizing that the purpose of the Mitchell plan is to do away with Government inefficiency, to get Government out of health care delivery systems. For example, Medicare and Medicaid, that will be privatized under the Mitchell plan. I think that is important.

I think it is also important to indicate we want to do away with the power of the insurance industry as it relates to health care. I will bet every Senator, and certainly every Senator's office, has heard time after time from physicians saying, "I am tired of not

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being able to practice medicine. I have to get it cleared with an insurance clerk or some other clerk who is going to tell me whether or not I can do a procedure." We need to get away from that, and the Mitchell plan does that. For example, in the majority leader's legislation now pending before this body, there is something set up called the National Quality Council. This is important because we want to make sure, after this is all over with, we have better quality medicine delivered and the consumer is protected more than previously. This national council will establish performance measures for health plans, including measures of access, waiting times, patient-provider ratios.

What that means is help if you are going to choose a health plan. When I choose one, I am part of 9 million other Federal employees. That is how many are in this Federal plan that the Presiding Officer, I am sure, and other Senators and staff in this Chamber—that is how many people are involved in that, 9 million members. We have a so-called open season, when each year we can pick a new policy. I would like to think I am fairly sophisticated in being able to understand difficult things. I cannot understand it. I do not know what all those policies mean. But if we had this, I would be able to understand because I would be able to tell, for example, for open heart surgery, what is the survival rate. You can compare plans. Institutions would have to put that out. If you have a particular plan, there would be a determination as to how long patients have to wait, on an average. These are the kinds of things that are in the Mitchell plan. And these are the kinds of things that will improve health care in our country.

I was just responding to some of the statements that had been brought up by the two previous speakers on the other side of the aisle. I hope that, before this is all over with, we will have a coalition, a uniting of Senators on both sides of the aisle. I am very sorry he left—I saw the senior Senator from Minnesota, someone who will be retiring from this body at the end of this year. I know he has spent a lot of time on health care legislation in his career. I hope he will see fit to join with the majority leader in working out something in this legislation. He has the knowledge, and we really need his experience and counsel. I think it would be a shame if he left this body without having had an imprint on health care legislation.

I say that to other Senators on the other side of the aisle. This is the time to get health care legislation. It is not the time to talk about how good it could be, but to do the possible. What can we do to improve health care reform in America today?

What I wanted to talk about today is small business. On the other side of the aisle we hear the constant drone that the Mitchell plan is not fair to small business.

Again, this is a wooden desk. It is not a horse. And no matter how many times they say that health care reform is unfair to small business, it will not sell because it is wrong. An indication of that is a telephone call I had last week, Thursday or Friday of last week. I had never heard the name before, but I got on the phone with a man by the name of Edward Atwell, from Reno, NV.

Edward Atwell runs a business, a small business. He has 11 employees. He works awfully hard. It is the Big-O Tire Co. in Reno, NV. He sells tires and fixes tires. Again, I had never met him, did not know he existed. He called me and said, "Senator REID, I am a dyed-in-the-wool Republican, always have been. But I want you to know as my Senator that I want you and your colleagues to do something about health care reform for me." He said, "I have 11 employees and I have health insurance for my employees." He said, "It is very expensive, but I want to do that for my employees. But it is getting harder and harder to do it." And he said, "The tire companies that have no health insurance have a competitive edge over me. Do something about health insurance reform. Do it for the small business community of America."

Well, Edward Atwell wants health care reform. Why would he be concerned as a small businessman? He is concerned because he knows that it is hard for him to get insurance, and he knows that once he gets it, it is hard to keep it. He has been fortunate. He has not had one of his 11 have a heart attack, get pregnant, get cancer—because if they did, his policy would never be rewritten the next time. Just like my ophthalmologist in Las Vegas whom I went to see to get my new glasses. He says, "Harry, you have to do something. I have 27 employees. They will not rewrite my policy because one of my employees got cancer. I cannot get them to rewrite it. I cannot find anybody to give me a policy for my employees."

That is why Mr. Atwell is concerned. Mr. Atwell pays about 35 percent more for the same insurance policy that big business pays. The same coverage, he pays 35 percent more. And, if that were not bad enough, he pays increases of 50 percent more than big business. So the mere fact you have insurance, if you are a small business person, keeps you going further and further in the hole. Mr. Atwell expressed, to say the least, his frustration with the skyrocketing premiums he has and the fact that he is having a difficult time competing. Small business owners who, like Edward Atwell, do the right thing, are penalized under today's system. That is only one of a lot of reasons why we have to change the system. Because they are paying for the health care of their competitors who do not provide insurance for their employees.

If I marched in here with 51 Senators and we said, "We have a plan for the American public and here is what it is. Everyone who wants to buy health insurance, or is lucky enough to work for somebody who provides health insurance—everyone who has health insurance, no matter how they get it, are going to have to pay for those who do not." The American public would say, "What, are you out of your mind? What kind of system is that? I thought you were doing your best to represent us?"

And I would say, "That is the system we now have." And that is the system we have now. Right now, the insurance system we have in America for health coverage is one where those who have it pay for those who do not in the way of higher insurance premiums, higher hospital and doctor bills, and higher taxes for indigent care. That is an unfair system we have today and it should be changed.

Under the plan submitted by the majority leader, small businesses would no longer be forced to pay 35 percent more than big business. The Mitchell bill creates purchasing pools to give individuals and small businesses bargaining power to get high-quality care and coverage they can afford and they can count on and not be canceled at whim as was my ophthalmologist's. Small businesses and individuals will be able to get coverage at the same rates as big businesses, and insurance companies will no longer be able to pick and choose who to cover. The Mitchell plan, in effect, puts the consumer back in the driver's seat for a lot of reasons.

If health care costs had been kept under control—that is, if health care costs had increased at the rate of growth in our overall economy for the past 12 years—small businesses, if they had insurance, would be paying an average of about $1,300 a year less per employee for health care coverage. Small business premiums have risen as much as 50 percent a year. This is from the U.S. Department of Commerce, a report they did in January 1994.

More than 90 percent of small business owners agree that health care is becoming prohibitively expensive and is a serious business problem. There are 90 percent of small business people who feel like Edward Atwell of Reno, NV. About 60 to 65 percent of small businesses have health insurance, but those who have it say, help us some way or we are going to drop it. We cannot afford it.

Nearly 70 percent of small business owners want to offer employees better health care benefits and agree all Americans have a right to basic health insurance. Small businesses, as I have indicated, Mr. President, now pay from 35 to 50 percent more than large firms for the same insurance. Large corporations can offer more benefits at a lower

cost, thus, putting smaller firms at a greater disadvantage.

Paperwork and administrative burdens on small businesses that offer employees coverage, costs firms as much as 40 percent out of every health dollar, while large firms average a nickel. So if you are a small business person, you have insurance, the administrative costs out of $1 paid eat up 40 cents; big business, a nickel. Small businesses can pay, as I have indicated, 35 percent more than large businesses for the same coverage. I mentioned that several times, but I have done it on purpose.

By the year 2000, if we do not do something, health care costs may eat up as much as 60 to 65 percent of businesses' pretax profits. In a poll, the NFIB, who is not, for a lot of reasons, excited about health care reform because of the way their institution is set up, found that 64 percent of small business owners would like to provide some or better health insurance to their workers.

Let us talk about the plan that is now up at the desk submitted by the minority leader. The Washington Post reported:

> The Dole proposal supports reform in name while largely avoiding it in fact.

Small business under that plan would face higher costs. Edward Atwell knows that and other small business people know that. It does nothing to protect small businesses with more than 50 employees who can still see premiums rise dramatically if a few of their employees get sick. Small firms can continue to pay more for administrative costs than large businesses.

The plan submitted by the minority leader exempts trade associations from community rating. This loophole, in effect, permits discrimination in premiums based on what the industry does. A small coal miner—there are lots of diseases involved in coal mining—they would have to pay more. No discounts for small businesses. Unlike that of the majority leader which provides millions of small business people the ability to have coverage for the first time, the plan of the minority leader offers no small business discounts.

There is continuation, under the plan of the minority leader, of discrimination against self-employed individuals. Self-employed individuals are denied 100 percent tax deductibility until the year 2000. Cost shift remains. Small business insurance rates would rise and small businesses are forced to share the cost of high Medicaid patients and other high-cost individuals.

There are incentives for small businesses not to take responsibility. Under the minority leader's nondiscrimination provision, if a business provides any insurance at all to any of its employees, they have to provide it to their low-income employees as well, without any discounts to help them pay for the coverage.

This will not work. And if it is a matter of choice, you know they are not going to have the insurance. If a business contributes any amount to their employees' insurance, even a minimal contribution, their workers would not be eligible for any low-income subsidies.

Mr. President, for those who have suggested that the best policy may be—and this is my term, not theirs—to muddle through with only small incremental changes, our analysis, my analysis, suggests that the number of uninsured workers in small businesses will continue to grow. In the publication "Health Affairs," they said:

> Thirty percent of small businesses currently providing insurance will drop their insurance coverage because of high cost.

It is only going to get worse.

We know that small businesses are the least likely to offer insurance today, in large part because insurance companies often limit small business access to insurance by refusing to cover some firms and dropping others from coverage whenever just one worker gets sick. And we have talked about that.

Mr. President, this is not a rare situation where small business decides not to carry insurance. In the State of Nevada, there is a woman by the name of Rose Dominguez. Rose is a woman who is involved in a lot of activities in southern Nevada. She is very interested in the community. She is interested in her employees. She has a travel agency. But she had to arrive at a point where she could no longer carry health insurance for her employees. The names are myriad in the small State of Nevada.

So, we know that small businesses pay at least three times for their insurance. They pay for their own employees, they pay for the dependents of their employees, sometimes, and third, they pay through higher premiums for the uncompensated care of other people. Higher insurance premiums, higher hospital and doctor bills, and higher indigent taxes for indigent care.

The system, according to the Wall Street Journal, will only get worse. I quote:

> By using their clout with health care providers to demand lower costs, big employers help squeeze out inefficiencies but also stop helping hospitals care for those with no insurance or with Government insurance. Those costs won't disappear, however. As big companies shed them, insurance premiums for smaller employers will be forced up.

I appreciate very much the Senator from New York yielding time to the Senator from Nevada. I have brought out two points: Malpractice reform, and I gave one example of a commission that will be set up so that consumers will have a better understanding of the health care that is provided to them.

I have also talked about small business. I have talked about small business because they need to be cut some slack, as told to me by Edward Atwell of Big-O Tires, Reno, NV. No matter how many times those who want to maintain the status quo, no matter how many times they say that we do not have health care reform in the matter now before the Senate, in the form of Senator Mitchell's bill, no matter how many times they say that, it will not work because it is not the truth. No matter how many times they say this desk is a horse, it does not matter, it is still a desk.

Mr. MOYNIHAN addressed the Chair.

The PRESIDENT pro tempore. The Senator from New York.

Mr. MOYNIHAN. Mr. President, I congratulate the Senator from Nevada. I remarked earlier on his great learning in this field and I particularly thank him for the points about malpractice reform. It is so important to the medical profession, and not just the doctors, but the nurses and all the people involved that we take this opportunity to relieve them of a needless anxiety, but anxieties which can be pervasive. If anyone gets to know people in this work, you will find that is on their minds all the time.

Mr. REID. Mr. President, if I can respond to the manager of the bill, I think we are trying to do the possible. I am a great supporter of having consumers have the ability to file a lawsuit and have their grievances redressed in a court of law. But still there are things that need to be done to make the system better.

I have only talked about a few of the things in the Mitchell bill, but I think it is a significant step forward and I wholeheartedly support Senator MITCHELL's attempt to reform medical malpractice.

I appreciate very much the comments of the Senator from New York.

Mr. MOYNIHAN. I thank the Senator. I yield the floor.

Mr. PACKWOOD addressed the Chair.

The PRESIDENT pro tempore. The Senator from Oregon.

Mr. PACKWOOD. Mr. President, I yield such time as the Senator from Mississippi may require.

The PRESIDENT pro tempore. The Senator from Mississippi [Mr. COCHRAN] is recognized for such time as he may consume.

Mr. COCHRAN. Mr. President, I thank the distinguished Senator for yielding me time.

It was interesting to me to read the accounts of the debates that we have had in the Senate in the New York Times and the Washington Post over the weekend. One writer for the New York Times talked about the misstatements and malapropisms and other errors that the writer perceived to have occurred in the debate during the discussion of the health care reform bill.

One very interesting story was written by Dave Barry: "The Power Trip. Washington Outsider Trashes Town." He talks about how there is nothing in Washington to make it look like the planet Earth. But then he talks about the health care debate and he did have this to say, which I am going to read. He says:

For more than a year now, the Clinton administration, Congress, and scores of special interest groups have debated the health care issue with such intense passion that their photocopying machines routinely burst into flames. This debate, although bitter at times, has resulted in a broad national consensus on two fundamental conclusions: 1. The United States has the best system of health care in the world, and 2. Something needs to be done about this.

Well, he then goes on to talk in his humorous way, as only Dave Barry can, about many of the other things that have made it possible for us from time to time to laugh at ourselves. But this health care issue is not really a laughing matter. I will agree what Mr. Barry points out in his first conclusion and his assessment of the national consensus is right when he says the United States does have the highest quality health care—and, I might add, with more choices—than any other nation in the world. That will be put at risk by the Clinton-style plan proposed by the Democratic leader. That plan will result in higher costs, longer waiting lines, and endanger the health care choices of most Americans. The mandates, the taxes, the alliances, and the premium caps all mean sweeping new Federal controls over American medicine.

Before we vote, we should ask: Do we really want to create this new Government-controlled health care program? And we should ask specific questions about their plan such as: What would the new overhead costs be?

Senator MITCHELL's bill would set up a National Health Care Cost and Coverage Commission and a National Health Benefits Board that would make many decisions about the kind of health care that would be available in the future to all American citizens, including decisions about medical necessity and appropriateness. Under this bill, many new State and Federal agencies would be established.

We had first heard in a report, in an analysis from our distinguished colleague from Indiana, Mr. COATS, that there would be 20 new State and Federal agencies created under the Mitchell bill—now we are told that that could go as high as 70—and many mandates imposed on the States, 177 new obligations imposed on the States, by this new Federal law if it is enacted. No one has been able to tell us what the new overhead costs of the program would be at either the Federal level or the State level. We also need to ask, we should ask: What has happened to the costs of the Federal health programs we already have?

In 1990, Medicaid spending totaled $41.1 billion. In 1995, Congressional Budget Office projections indicate that Medicaid spending will total $105 billion. From 1990, $41.1 billion, to 1995, $105 billion; a program we already have. This could be an indication of the kind of cost spiral we will see if the Federal Government were to administer our entire health care system.

We should also ask about the costs of other entitlement programs and how much they have increased in costs during the past 30 years.

I have a chart here—and I apologize for using a chart, but it clearly illustrates better than I can in just my statements—showing how entitlement costs have grown over the last 30 years.

From 1963, if we look at this line here as illustrating 100 percent of the Federal budget—this is the total Federal budget line here from zero to 100 percent—the discretionary spending in 1963, that which the Appropriations Committee approved for allocation among all the Federal activities and programs, amounted to 70 percent of the total budget. Entitlement spending—Social Security, Medicare, Medicaid, other programs that were mandated by law, to which people were entitled as a matter of law—amounted to only 30 percent. In 1973, that had gone up to 45 percent, in 1983 to 56 percent, and in 1993, just last year, it reached 61 percent of the total Federal budget. And the projections are that even without this new health care plan, which will increase entitlement spending considerably, we will have a Federal budget that will require 72 percent of total outlays to go to support entitlement programs, and only 28 percent by the year 2003 that would be available for discretionary spending.

A recent article in my hometown paper, in Jackson, MS, the Clarion Ledger—it was written by Miles Benson for Newhouse News Service—talks about this entitlement spending trend and what it means in the context of the health reform proposals before the Congress. He says:

Over the years, the Government has promised a lot of costly benefits to middle-class Americans and now it is trying to make one more big one—universal health care. But where is the money to pay for Social Security, Medicare, and a plethora of previous promises? Their fast-growing costs, along with interest on the national debt, add up to 60 percent of all Federal spending, even without the enormous added expense health reform will bring. Unless changes are made soon, the Government won't have enough money to continue even the existing programs. And that means either higher taxes or benefit cuts or both.

He goes on to say, in another part of this article, which I will ask unanimous consent be printed in its entirety at the conclusion of my remarks, that:

The fastest-growing entitlement programs are Medicare, which helps 35 million elderly and handicapped people pay their medical bills regardless of their income from other sources, and Medicaid, which pays for doctors' care for 30 million. The costs of these two programs are expected to increase at a rate of 10 percent per year over the next decade, increases driven by the growth of the eligible population, the increasing intensity of medical services available to participants, and hyperinflation in the costs of health care.

Medicare hospital insurance payments already exceed tax revenues dedicated to the program, and the trust fund dedicated to the program will run out of money within seven years unless something changes.

And he concludes by saying:

President Clinton insists his health care reform plan would, over time, curtail the growth of health care costs, but he also seeks to extend health care coverage to 39 million uninsured Americans financed partly by new Federal subsidies. And he wants to broaden the benefits available under Medicare and Medicaid. Many experts believe expanding coverage will substantially drive up Federal spending on health care.

Mr. President, I ask unanimous consent that the entire article by Miles Benson of Newhouse News Service be printed at the conclusion of my remarks.

The PRESIDENT pro tempore. Without objection, it is so ordered.

(See exhibit 1.)

Mr. COCHRAN. Mr. President, the Mitchell plan creates at least eight new entitlements. It commits the Federal Government to new entitlement spending which is estimated to be $1.5 trillion over 8 years. And, if it does not work to achieve the predetermined goal of coverage, then employers will be required by the new Federal mandate to pay one-half of the premium cost of their employees beginning in the year 2002.

Somebody asked me, "Why is this delayed? If you need the money now, why put it off for this long period of time?" I frankly think the reason is political. One reason is that people who have to pay this tax will not know who voted for it when they have to pay it. I mean, we are putting it over from now, if it is enacted this year, to the year 2002. And those folks who are going to have to pay this new payroll tax, which is what the employer mandate turns out to be, are not going to know who is responsible. As a matter of fact, somebody suggested that may be why they called it a trigger. The trigger means that if they do know who did it, they might shoot them. But the fact is, if States are not up to the 95 percent coverage rate by the year 2000, those businesses in that State with 25 or more employees are going to be required to pay the new payroll tax.

Who will that be? The National Federation of Independent Business has done a study trying to estimate and determine what States are going to be required to pay this added payroll tax. Not all States may be covered by it. But there is a way to figure out now which States are the most likely that have to pay. They did this list.

Mr. President, Mississippi and West Virginia are at the top of the list. Utah, New Mexico, Arkansas, Louisiana, South Carolina, Montana, Idaho, and Oklahoma, and it goes on down through a long list of 25 States that most likely will have to pay this tax. Ohio is the 25th.

As a matter of fact, we have done this in a graphic so you can get an idea just by looking at a map of the United States. Almost the entire South, except Florida, is covered, and the Southwest out to Arizona, including New Mexico and Arizona, and the upper Northwest, except for the State of Washington, will be covered; some of the heartland States right here in the industrial Midwest, Indiana, Ohio, West Virginia, Kentucky. The fact of the matter is, do not forget Maine. They are one of the most likely to have to pay this tax too.

What they have done is try to determine the number of people who are now covered by insurance in all of the States, and the per capita income of the residents of all those States to figure out for which States it will be hard to meet this predetermined 95 percent of coverage. These are the States. So they are the most likely to have to pay the tax.

Where do you need the economic growth the worst? It is in many of these States. We need new jobs. We need to be attracting new industry into these areas to help provide jobs. But if you are going to have a new requirement now that employers in those States have a mandate to pay premium costs for health insurance and the other States do not have it, what is that going to do to your opportunity to attract new business, to create new jobs? I say it hurts it. It puts you at a disadvantage. That is what this mandate does, as far as economic development and the attractiveness of certain States as compared to others.

Senators ought to think about that. Some say that the mandate is bad, it is bad for business, it may cost jobs, and it may be harmful to our entrepreneurial spirit as a country. If it is bad now, it certainly is just as bad in the year 2002 when it will be triggered, if this predetermined 95 percent of coverage is not achieved. Most think, obviously, that some States will not achieve it or cannot because of demographic differences, because of economic differences, and because of the realities that exist out there in the real world.

Senator MITCHELL's bill states that if a 95-percent coverage target is not achieved by the year 2000, the employer mandate would be triggered requiring businesses with 25 or more employees to pay 50 percent of their employees' health insurance premium costs.

Many experts tell us that these mandates, these new taxes, on selected States, would destroy jobs, threaten the survival of many businesses, and reduce wage growth. If mandates are a bad idea today, when they are triggered they will be a bad idea then.

A triggered mandate only in States that do not achieve that 95-percent coverage will hit the small business-intensive States the hardest. I do not know how many businesses will actually fold up. Nobody does. Those who cannot afford the new costs, because they are on a tight profit margin or maybe no margin of profit at all; there is no question that fewer new businesses would be started in those States that have to have the new tax. They have many other burdens imposed by the Federal Government already that cost money, that add to overhead.

Studies conducted by Consad Research, the Urban Institute, and others, forecast anywhere from 700,000 to 3 million jobs will be lost as a result of the new employer taxes. A Gallup Poll of small business owners indicates that a majority of them would either let some employees go, restrict wage increases, or increase prices as a result of an employer mandate. No matter which job loss study you look at, they all point in the same direction—employer mandates cost jobs.

I would suggest that another serious result could be that many small business owners will decide that it is just not worth the hassle to stay in business, and others who might otherwise consider starting a new enterprise would be discouraged from doing so, especially if they are in a State where the trigger has been pulled.

When these new taxes and new regulations are combined with other burdens that are placed on small business by the Government, the American entrepreneurial spirit surely will be dampened, and our economic vitality will be put at risk.

Mr. President, some of the rhetoric we heard has suggested that Republicans want to stop health care reform in its tracks. I think most Republicans in the Senate want to solve the problems in the health care system. We can do it by providing portability of coverage, and eliminating unfair underwriting practices, by providing subsidies and tax breaks to assist people in getting and keeping the coverage they want. Senate Republicans produced two comprehensive health care plans last year, one sponsored by Senator JOHN CHAFEE and the other sponsored by Senator DON NICKLES.

This year, 40 Senate Republicans joined in support of Senators DOLE and PACKWOOD when they introduced their plan that also confronts the real problems that exist in today's health care system.

The Dole-Packwood plan enhances quality, preserves health care choices, controls costs, and promotes security without imposing the new taxes that will unnecessarily burden small businesses and their employees.

The Dole-Packwood bill has the greatest support of any plan in the Senate, including the proposal of President Clinton and Senator MITCHELL.

The Dole-Packwood plan would provide choice to ensure that consumers, and not the Federal Government, decide how they get their care, and from whom; preserve American jobs by protecting small businesses from job-destroying mandates and taxes; increase access and remove the fear of losing insurance because of job loss or job change, moving, or a serious illness; maintain quality to ensure America's health care remains the best in the world, and consumers do not pay more for less care; be financially responsible, by phasing in financing of reform as other savings are available and not through deficit spending or increased taxes; achieve flexibility by allowing States and localities options to design plans best fitting their particular needs.

Mr. President, we should not adopt the Democratic leader's newest version of the Clinton plan, which would mean quotas on doctors and training; a premium tax on graduate medical education; Government spending limits that will lead to rationing of care, higher levels of taxation, new entitlements, and a big, new Federal bureaucracy.

Before passing the Clinton-Mitchell bill, we should remember the enactment and repeal of catastrophic insurance in the Medicare program in 1988 and 1989. The lesson of this experience is that it is not enough to promise health care benefits to Americans. We have to make it clear how any new program will affect them and how much it will cost them, and we need their support. Last time out, we forgot to do that. We should not make that mistake again.

I suggest when all the facts are understood, American citizens will prefer the Republican alternative, because it will mean less bureaucracy, less costs, more quality, more choices, and no new taxes.

I urge the Senate to reject the Mitchell bill.

EXHIBIT 1

UNLESS ACTION TAKEN, RETIREMENT MEANS POVERTY

(By Miles Benson)

WASHINGTON.—Over the years, the government has promised a lot of costly benefits to middle-class Americans and now it is trying to make one more big one—universal health care.

But where is the money to pay for Social Security, Medicare and a plethora of previous promises? Their fast-growing costs, along with interest on the national debt, add up to 60 percent of all federal spending, even without the enormous added expense health reform will bring.

Unless changes are made soon, the government won't have enough money to continue even the existing programs. And that means either higher taxes or benefit cuts or both.

The middle class and the wealthy, who receive more than half the benefits, will feel the pain, as well as the poor, and there's very little anyone is going to be able to do about it.

The current generation of people in their 60s may be the last generation to collect the full benefits now available from Social Security.

Rising health care costs, longer life expectancy, and the advancing legions of 76 million baby boomers, who will begin retiring at the end of the next decade, are setting the stage "an economic and social disaster," said Sen. Robert Kerry, D-Neb., who wants President Clinton and Congress to begin dealing with the problem now.

The technical name for these benefits is entitlements, and Kerry chairs a 32-member Bi—Partisan Commission on Entitlement and Tax Reform. The commission will report its recommendations in December.

According to commission members, administration officials, congressional budget experts, and numerous outside economic experts, this is the reality the nation faces:

If allowed to continue without change, entitlements plus interest on the federal debt will consume all federal revenues by the year 2012, just 18 years off, leaving nothing for defense, disaster relief, law enforcement, air traffic control or anything else—including the salaries of federal workers who write the federal benefit checks.

Financing the entitlements in their present form could require a 50 percent increase in all federal taxes on current and future generation of taxpayers—increases that would be politically impossible to enact and, even if enacted, would probably be self-defeating. The economy would collapse under their weight.

Deficit financing would be equally unrealistic. Such deficits would dwarf even the monster deficits of recent year years. blocking investments needed to boost productivity, create jobs and raise living standards.

Some combination of increased taxes and reductions in benefit levels is inevitable, many experts, believe. These solutions could include caps on spending or reducing benefits to middle- and high-income people. Some economists are studying the feasibility of new taxes on consumption.

Today, entitlement programs automatically pump out benefits to every eligible person who signs up for them. The biggest are Social Security, Medicare, Medicaid and the federal retirement system covering both civilian and military retirees. These four programs account for 75 percent of entitlement spending.

The rest consists of much smaller programs that include, in descending order of cost, food stamps supplemental security income payments that go mostly to the disabled and to poor elderly people, veterans benefits, welfare payments to mothers and children, agricultural price supports and earned income tax credits for the poor.

This year, 1994, total entitlement benefits come to $800 billion. More than half of all entitlement benefits go to middle-class and affluent Americans. In the case of Social Security, the average retiree is getting back far more than he or she paid in plus interest,—on average $40,000 more per retiree over his or her lifetime.

And under this system, families with private incomes of more than $50,000 a year got $49 billion in Federal benefits in 1990. About $12 billion of those benefits flowed to families with income of more than $100,000.

Last year, the 2.2 million federal civilian and military retirees received benefits worth $65 billion.

Many experts say those now in the 60s are the last generation that will enjoy such a sweet deal. The generosity of benefits will subside because there won't be enough money to support them. And future retirees will have paid higher taxes for a longer time than current retirees.

Workers with average earnings who retired in 1980 got back their retirement taxes—the share paid by themselves and the share paid by their employers on their behalf-plus interest in less than three years.

When average-wage workers now in their late 20s retiree, they will need more than 18 years to recover their contributions—two years longer than their life-expectancy. And that assumes the money will be there to pay them, which it won't be if benefits aren't cut or the taxes aren't raised.

The fastest-growing entitlement programs are Medicare, which helps 35 million elderly and handicapped people pay their medical bills regardless of their income from other sources, and Medicaid, which pays for doctors' care for 30 million poor. The costs of these two programs are expected to increase at a rate of 10 percent per year over the next decade, increases driven by the growth of the eligible population, the increasing intensity of medical services available to participants and hyper-inflation in the cost of health care.

Medicare hospital insurance payments already exceed tax revenues dedicated to the program and the trust fund dedicated to the program will run out of money within seven years unless something changes.

President Clinton insists his health care reform plan would, over time, curtail the growth of health care costs, but he also seeks to extend health care coverage to 39 million uninsured Americans financed partly by new federal subsidies. And he wants to broaden the benefits available under Medicare and Medicaid. Many experts believe expanding coverage will substantially drive up federal spending on health care.

Social Security is the third rail for elected officials—touch it and you die.

Social Security means regular monthly checks to 42 million elderly and disabled and members of their families this year. For millions of Americans, the benefits are all that separates them from poverty. For additional millions of already affluent elderly, the benefits are merely gold-plating on an already secure and dignified retirement.

Thanks to lengthening life spans, the average couple retiring today can expect to collect Social Security checks for 25 years. The insurance value of that pension combined with Medicare benefits is more than half a million dollars.

Older people, one of the country's most potent blocs of voters, are organized to fight any attempt to reduce benefits. The flavor and intensity of the opposition is evident in the blizzard of mail already pouring into the entitlement commission's offices on Capitol Hill.

"If you intend to mess with Social Security, you all should be thrown out of office," wrote one enraged senior. "It's our money, not to be used by you or no one."

Said another: "Don't fool with Social Security. Don't try balancing the budget with my money."

For now, the tax structure of the Social Security system generates a surplus that reduces the federal deficit and helps pay for other federal programs.

But the surplus will disappear during the next 20 years as the baby boomers retire and the payouts to them surge. Unless changes are made, the Social Security trust funds will run out of money to pay benefits to today's 20- and 30-year-olds when they are ready to retire. Today's 40-year-olds would drain the funds dry by the time they are 75 years old.

Low birth rates and longer life expectancy mean that the ratio of workers to retirees is shrinking. In 1950 there were more than seven workers paying taxes to support the benefits of each retiree. In 1985 there were five workers for each retiree. Today there are four and by 2030 there will be fewer than three.

"What it really boils down to is that revenues and spending in our budget as a whole are out of whack, out of balance," said Robert Reischauer, director of the Congressional Budget Office.

"We can solve the problem by cutting back on entitlement programs or cutting back on non-entitlements or by raising revenues. The answer to the dilemma will be a little of all three," Reischauer predicted.

The problems are clearly visible now. They will be no surprise when they erupt as full-blown crises—if nothing is done now.

"If we do something modest and prudent now we can avoid taking more drastic remediation 15 years from now," Reischauer said.

For example, putting the Social Security system into balance for the next 75 years would require a 1 percent increase in payroll tax on employees and employers, if that is done now, Reischauer said.

Meanwhile, younger workers cannot expect they will get as much out of the system as current retirees.

"The system was very good to our grandparents and parents and people retiring right now, because it represented a huge intergenerational transfer," Reischauer said of the shift of wealth from the young to the old. "But that will not be true in the future unless life expectancy takes another big jump."

In the mid-1930s, when Social Security was established, the average life expectancy was 60 years. Today it is 76. Under current law, the age for full benefits retirement will increase gradually from 65 to 67 between the years 2000 and 2017.

Crusaders for sweeping entitlement reform, like Peter G. Peterson, former Secretary of Commerce, and former senators Paul Tsongas, D–Mass., and Warren Rudman, R–N.H., urges raising the retirement age to 68 to 2006, reducing Social Security and Medicare benefits to retirees with incomes above $40,000 a year on a sliding scale as incomes go up.

Reform of the Social Security System, in both the financing and the benefit, is "inevitable" said C. Eugene Steuerle, an economist at the Urban Institute, a public policy think tank.

"Social Security will be there and remain a fairly generous system, but we must cut back on some of the built-in growth," Steuerle said. The budgetary problems are self-induced, the result of the fact that people are living longer and getting better health care. "In a crazy way, it's a nice set of problems to have," Steuerle said.

But changes must be made, he warns.

"Every year of delay in resolving these issues will make the required changes harder and harder to bear," Steuerle said. "Expected liabilities are accumulating quickly relative to assets and anticipated revenues. The longer that reform is delayed, the greater the adjustments required of beneficiaries and taxpayers."

Mr. RIEGLE addressed the Chair.

The PRESIDENT pro tempore. Who yields time?

Mr. RIEGLE. I yield such time as I may consume off of the time of the majority.

The PRESIDENT pro tempore. The Senator is recognized for such time as he may consume from the time under the control of Mr. MOYNIHAN.

Mr. RIEGLE. Mr. President, let me just say that when the Senator from West Virginia assumes that position, there is no finer Presiding Officer.

This issue that we are here to try to deal with—namely, health care for our country—is a vital issue for our people. It certainly is in the State of West Virginia, where the President pro tempore comes from, and in my home State of Michigan. I know there is great frustration in the country as this debate has gone on now over several days in the Senate. I think citizens listening to this and watching think that probably all we do is talk and that nothing more than that happens, or at least not as often as it should.

I think we are reaching a point in this debate where a lot of the words are more for effect and have a purpose other than trying to settle the issue, because this question of health care reform has been around a long, long time. It goes back, in fact, for decades.

One of the prior Presidents had offered a plan very similar to the Mitchell bill or the Clinton bill that has been put forward. It was President Nixon, who at that time was a Republican President; but to his great credit, he saw the need to try to reform the health care system, to make it less expensive, less bureaucratic, and try to make sure everybody had a chance to have insurance, especially working families, so they could protect their children and all their family members.

I must say that over the last 2 or 3 days, the debate has taken on much more of the character and feeling of a filibuster—namely, a tactic of delay, rather than actually getting down to and voting on the basic aspects of a health care reform plan.

We actually have an amendment on the floor right now. It has been presented at the desk, and we are ready to vote on that. It is offered by Senators DODD, KENNEDY, and myself, and I believe there are other cosponsors. It is designed to expedite coverage of preventive health services for children and pregnant women in our country, to make sure these services are the first covered in the standard benefit plan—in July of 1995, instead of January of 1997. Those, today, in working families who do not have the protection of comprehensive insurance will get it under this plan. So that is the first amendment. It has actually been sent down to the desk. It is in writing and is down there right now. If this odd kind of filibuster were to stop, we could vote on that in the next 10 minutes, and we could find out where Senators are. There are 100 of us here, and we all have the chance to vote and settle that issue, and then we would be ready for the next amendment. And that might be an amendment from the Republican side. They could come to the floor and present it, and we could have a period of debate on that and then vote, it either wins or loses, and that issue is settled and we go on to the next issue. We can work through these issues, I think, and get them done this week, if Senators were willing to actually decide these questions rather than just use endless debate as a delaying tactic.

I want to talk a little bit about the amendment we actually have at the desk and what it is designed to do. I want to make reference, as I have before, to an article that ran some time ago in the Detroit newspaper in Michigan. It is a story about a woman named Cynthia Fyfe. There is a picture of her here, and this is her 6-year-old son Anthony in the lower part of this picture. He is wearing glasses. Obviously, he needs them and fortunately has them. This article says, "She Can't Pay Her Big Medical Bills." It goes on to explain in the text of this story her situation. She is a single parent, a working mother, as are millions of women in America today. She has partial insurance at her workplace for herself, but none for her 6-year-old son, Anthony. In fact, their health insurance is so inadequate that when she got sick, she had a lot of expenses associated with the care that she needed, and her health insurance did not cover most of it. So now she owes nearly $3,000 in medical bills, and she cannot pay.

It talks here about how they live very modestly, in a trailer park, and she uses just about every cent she has just on the bare essentials of food and clothing and shelter for herself and her son. But Anthony does not have any health insurance. This little fellow right here, and millions more like him in our country today, have no health insurance at all. So if he gets sick and she has to take him in for care, whether it is to a specialist or, God forbid, if he were stricken with something very serious like appendicitis or such and she had to take him to the hospital for acute care, she has no insurance that can cover those expenses. So, obviously, he is unprotected. And people in this situation are also oftentimes reluctant to take their children in for care when they need it, because they have no way to pay the bills. That is the situation here.

The irony of it is that if Cynthia Fyfe would quit her very modest-paying job and go on welfare, go on public assistance, then she would receive health care coverage; she would receive it under Medicaid, and so would her son, Anthony. So one way she could get health care coverage for her son is to actually quit her job and go on welfare and then, under our system, we would provide health insurance to this little 6-year-old boy in Detroit.

When you hear that, you almost wonder if you are hearing right. Can it be possible that in America we have things so upside-down that we say to a mother who is out there working, who obviously loves her child and wants to provide health care insurance coverage for her child, that if she cannot earn enough to be able to pay for it, that if she will quit her job and go on welfare, then we will see to it that she can have health insurance for herself and also for her son?

That is what we are trying to fix here. It is not that complicated. It is pretty darn simple, although we have heard a million words spoken here over the last 4 or 5 days since this amendment has been sitting down at the desk. But the amendment is very straightforward. It has to do with seeing to it that we provide comprehensive coverage for these children in America who today do not have comprehensive care.

We are not talking about frills. We are not saying let us enable this child to go down to a fancy department store and pick out a whole wardrobe or have some fancy house to live in or to give someone a big car to drive.

We are talking about something a lot more basic and a lot more important than that. We are talking about the question of making sure this little kid has a chance to grow up and be well and healthy in America, which every child in America ought to have the chance to do, because every child in this country is important. You should not have to be born into a certain family situation or to be in a favored status in some way or another to be important enough in this country as a child to have health care protection. Every child should have it, because every child is important.

If we were driving down a highway right now and we came upon the scene of an accident that had just happened ahead of us, a car had gone off the road and a terrible accident happened and people had been hurt, and if there was a child there by the side of the road needing help, would we just drive on by? Would we just drive right on by that child and keep going? Of course, we would not. We would stop, and we would get out, and we would help. You would try to save that child's life and see that that child got the care it needed.

But as a country right now we are driving right on by these children. It is as if they are not really there or—we obviously know they are there—it is as if they do not really matter or they do not matter enough.

But what is this country? What is America? Is it just this great big piece of real estate? Is it just something we call a country that we started over 200 years ago? That is part of what we are. We are a nation of people, and we are bound together in this Nation in a relationship to one another where the well-

being of America, our country, in the future depends upon how our people are able to live. Can they work? Can they get an education? If they are living in West Virginia, do they have a chance to take the talents that they have within themselves and develop those talents? Or if they are in Michigan, or one of the other 50 States, do they have the chance to come forward and make of themselves what they can?

But if you need eyeglasses or you need to go to the doctor or you need your immunization so that you do not get some dread sickness, or as in the case that we have seen in my own family circle when my daughter Ashley, nine and half when it was found she had a terrible appendicitis, nearly died, the doctors could not figure it out for a while. Thank God, she got the care in the end that enabled her to survive.

There are kids across the country right now with problems like that. Anthony needs help. How important is he? Is he important enough for us to do something about?

I think we ought to vote on this amendment and do something about helping children like this, because this matters. This is important. It is real. It is tangible, and it will make a difference in terms of making our country stronger for the future.

You say, well, wait a minute. You are just talking about this little 6-year-old boy and are now talking about the country being stronger. What is the connecting link? The connecting link is that our country in the future is going to have this little fellow, and boys and girls all across this country—they are what our country is. They are our future.

So we want them well and healthy and strong. We also want them well educated. We want them to be able to go into the work force at a point in time to support themselves and to support the country and strengthen the country. That is what we want. I think that is why we came and formed this country in the first place. It was for those kinds of basic things.

Now, what is so ironic is that every other country in the world, every other advanced country in the world and many of the not very advanced countries in the world have decided this issue is so basic that they provide health insurance coverage one way or another for their children because they understand the importance that those children have to their Nation.

But there is another part to this. I mean, our people are the heart and soul of this Nation. We want them well and healthy and able to function at full potential. But there is another part to this, and that is just the basic humanity and decency of it and whether we care about whether other people suffer, whether someone else's pain matters to us.

Well, on that count, I am thoroughly one of those people who feels strongly about other people that I see who suffer needlessly. It bothers me. I do not have to know who they are. They do not have to be from my town. They do not have to be my race. They do not have to be my gender. Whoever it is, if I see that, I feel badly about it, and I want to do something about it. I want to help that person get out of that situation of pain or misery or danger to their own well-being.

I do not understand why everybody does not feel that way. But some feel it more strongly than others obviously. But I think we ought to help people who need help because it is the right thing to do. I do not think we ought to leave people in pain. Today we have an epidemic of breast cancer in this country. I do not think we ought to leave women in this country with undiagnosed breast cancers because they do not have the money to get regular preventive care and get mammograms and other things they need to find out if they have this problem so it can be dealt with in time to save their lives. The same with other problems, but especially with the children, because the children are very vulnerable, and they cannot fend for themselves quite the same way.

This little fellow right here, if he had the strength and the ability to give his mother two or three times the income that she now has so they could live at a higher standard and have health care, surely he would do it, but he is 6 years old. He cannot do it. He cannot do it for her, and he certainly cannot do it for himself. But we can do it for both of them, and we ought to because it is decent and because it is good for the country. It will make us stronger and better as a nation. We want this little kid to succeed. We want him to know his country cares about him.

Well, there is a way for us to let that message come through loud and clear, and it is to vote for this amendment that is at the desk right now that has been there for 4 days. Some tried to talk it to death. Let us vote on it. If you want to vote against it, vote against it. I want to vote for it. I think when people have to cast their votes on this, I think there will be more votes for it than against it, because I think most Senators understand the value and the moral and imperative aspect of seeing to it that children in this country have the kind of health care protection that they deserve.

So let us vote on it. If you want to vote it down, vote it down. But let us not just talk about it endlessly hour after hour, day after day, because there are needs out here. This little fellow is counting on us to get something done here and not just come in here and blow a lot of hot air at each other.

Cynthia Fyfe has just a little bit of coverage. But how does a child feel about the fact that his parents or parent is in a situation where they are going without health insurance coverage, let alone themselves? I mean, children love their parents. Think of the anxiety these people live with every single day.

Do we want to live with that anxiety, those of us fortunate enough to have health insurance coverage? Are we prepared to give ours away or to do without it? Of course not, because we know how important it is. We would not want to put our family members in that kind of position of insecurity and danger. If you do not treat health needs ahead of time when you can or promptly when they arrive, it is dangerous. People die.

I talked last week about Cheryl Eichler, a 29-year-old woman in Michigan, who was the manager of a 7–Eleven, with Crohn's disease; as lovely a person as I ever met. She came to testify before our committee one day on health care needs. She actually left the hospital to do it because she felt so desperately about the need for working people like herself to have health insurance coverage. She could not have it; did not have it; and could not afford to pay these medical bills. Oftentimes, she would delay going to the doctor when she was having terrible pains from this Crohn's disease.

She died 6 months after she testified before our hearing, not quite 30 years old. There is no doubt in my mind she would be alive today if she had gotten health care when she needed it. She should have gotten it.

Other people in the country should have it. I am willing to pay my share so that other people can have it, because I do not want their kids going without the things they need. It is not good enough in America that some of us have it and some of us do not, not in this area.

We are talking about something here that you need to have. We are talking about trying to keep people well and healthy.

It is so basic and it is so fundamental. Why is it that we have such a hard time understanding the need to do it?

I am open to the way to do it, quite frankly. If somebody can offer a better amendment than we have here, then I am willing to look at the amendment, as long as it covers the kids and the expectant mothers, as well.

Why do we include expectant mothers here? Because we know that if a woman is carrying a child, if she goes to the doctor and gets good prenatal care, that child is going to much more likely go to full term, the full 9-month term of the pregnancy, and be a healthy baby, and then have a prospect for a good life down the road because they got off to a good start during the pregnancy and during the birth process.

We know that we save many times over the money we spend on prenatal care for an expectant mother in terms

of a good outcome from that birth, as opposed to denying that care and having the baby come early or having problems that could have been prevented and then spending tens of thousands of dollars, or even sometimes millions of dollars, to try to help these little tykes. Oftentimes, it is done through Medicaid, through the public assistance system.

But it makes no sense. It does not make sense economically and it does not make sense morally. So we have to stop doing that.

You know, that does not build a strong America. That hurts America. It hurts us in terms of our basic strength, because we are squandering people and squandering money and we are not holding ourselves out to a higher standard, which is what we ought to do in America. We sort of lift ourselves up to a higher standard of conduct with respect to what happens in our country that affects the lives of our people.

Do you want people to love America? Do you want people in the underclass to care about this country? Well, I think we better make it clear that the country cares about them, as well; that this is a two-way relationship. I think it is so fundamental.

You could go into any church or synagogue or mosque in America or around the world and listen to what is being said by the religious leaders about what our relationship ought to be to one another. If there is not a foundation, a moral and an ethical and a religious foundation, in looking after each other's health needs, I do not know where there is one. It is so manifest.

I have seen it, you know, in hospitals, as everybody here has. I lost both my mother and my father in the last 2 years. That has been a terribly painful experience, and I know what it is like for everybody else that goes through it.

I watched, in the intensive care ward in St. Joseph's Hospital in Flint during both of those occasions, the dedicated services of the nurses, particularly, and the doctors and other caregivers to try to help people in these extreme situations. And I saw families, in addition to my own, going through these terrible moments, the travail and heartache and loss; sometimes recovery.

Do we not want to be there helping? Do we not want to help each other? If we pass that accident scene by the side of the road, do we not want to help? I hope that we are the kind of country that, in our heart and soul, would say, "Yes. Yes, we want to help."

We do not want to just go to Somalia and help; we do not want to just go to some other country around the world. We help every other country in the world, and a lot of that is necessary, and certainly it is driven by a humanitarian impulse. But is it more important to help the rest of the world than it is to help our own people? Are we going to find the money to help somebody in some distant land that we will never see, and say to little Anthony Fyfe here, "I'm sorry; we can't get you up on the radar screen. You are not that important. We'd like to help, but we can't find the money. We can't, we can't, we can't, we can't."

Well, we can. We ought to start voting. The whole weekend went by with talk, even though there is an amendment right down at that desk right now. That reading clerk right now could call the roll on that amendment, and every one of the 100 Senators could say yes or no, and we could settle that issue. We could decide whether we want to cover the children or we do not want to cover the children. And then we could go on to other issues.

I will finish in just a moment here. I feel very strongly about it.

I think this is a very important moment for our country. There are times when we have a chance to sort of grow as a nation and grow up to a higher level of achievement and relationship of our Nation and ourselves to one another. This is one of those moments.

It would be nice if it were simpler. The health care system is, by its very nature, complicated. It is 14 percent of the economy. It touches everybody in the country in one way or another. We know that going in.

But there are some basic elements, some basic truths embedded in all of this, and one, sort of the bedrock is, are we going to see to it that people get the health care coverage and protection they need? Are we going to do that? Yes or no? Are we going to see that it gets done?

Right now, this amendment says, all right, let us just take one group in this society. Let us take the most vulnerable group. Let us take the children, because they are not, in many cases, able to fend for themselves; certainly not 6-year-olds or 2-year-olds or 6-month-olds. They need somebody else helping.

And if their families are in situations where they cannot get health care, cannot afford health care—now, if this little boy right now had asthma and his mother had money, she could not buy him a health insurance policy even if she had the money, because the insurance companies do not want to insure a kid who needs the insurance. That is a preexisting condition. They would say no, we do not want Anthony because he has an asthmatic problem.

He is part of America. I want Anthony insured. I want every kid in America insured so they can get the care they need when they need it because it is right and because every child in this country is as important as every other child in this country. You should not have to be the child of somebody who is rich and famous and powerful, with a lot of money, in order to get health care protection in America. It ought to be there for every last kid in our country because each one is important. Each one is important.

So let us vote. Let us vote—or at least let us set a time to vote. It is 10 minutes to 2 o'clock. What if we talk until 4? Or talk until 6? Or talk until 8? Or talk until 10? Or talk until midnight? Or talk all night, if people want to talk all night. But then let us have a vote down here. Let us let that reading clerk right there call the roll. Call the 100 Senators' names, and let us find out where people are.

If we do not have the votes then we do not have the votes. I think we may just have the votes. We will find out. But it is time we start voting and put an end to this filibuster and these delaying tactics.

Once we have dealt with this amendment we will take an amendment from that side because we are going to rotate amendments. This amendment has come off the Democratic side. The next amendment, once we dispose of this one, will come off the Republican side. We will debate that amendment. And we will all vote on that and we will settle that issue and then we will rotate back over to an amendment on this side.

But let us get at it. The country deserves an answer on this and not just a lot of additional hot air. We have an amendment at the desk. I have helped draft it. I think it is time that we vote on it.

I reserve the remainder of my time.

Several Senators addressed the Chair.

The PRESIDENT pro tempore. The Senator from Oregon.

Mr. PACKWOOD. I yield to the Senator from Missouri such time as he may need.

The PRESIDENT pro tempore. The Senator from Missouri [Mr. BOND] is recognized for such time as he may require.

Mr. BOND. Mr. President, my thanks to our distinguished ranking Republican on the Finance Committee. I wanted to congratulate my colleague and good friend from Michigan for his very compelling comments on why health care reform is needed. There are clearly some very, very good reasons for us to pass health care reform. That is why many of us on this side of the aisle have been working for better than 4 years to develop effective, responsible, and private-sector solutions to the problems that we face in health care.

It has been mentioned that we are engaged in endless debate. Let me point out to my colleagues and my constituents that we are seeing some very significant changes going on, literally as we speak. As we all know, there was a bill passed out by the Finance Committee and a bill passed out by the Labor Committee. Now our majority

leader put forward, about 2 weeks ago, the Clinton-Mitchell I version. We started to work on that. And last week, then, another 1,400-plus-page bill, Clinton-Mitchell II, came out. And we had been working to understand what was in the first Clinton-Mitchell bill and we found out that there were some changes. Some of them were good. There were some outrageous things in the first one that were dropped out.

I think my colleague from Michigan would be interested to know that one of the things, unfortunately, that was dropped out of the second Clinton-Mitchell version was something that he and I have been working on, on a bipartisan basis, for several years. We believe that one element, an important one but just one element in health care reform, is to establish a system by which we can go to electronic filing for health care insurance claims file processing and paying. This was developed on a bipartisan basis with the active participation of the Department of Health and Human Services, the people in the industry who provide health care information, groups from health care providers to the American Civil Liberties Union. We were working because it makes no sense to have a quill and scroll kind of recordkeeping in health care when it takes up one-seventh of the American economy. We waste $150 to $180 billion a year just on pushing paper, and it is a headache for each one of us who are consumers. It takes up too much time, it wastes money, and besides, we do not have good information on which to base long-term decisions about the utility of various health care procedures. It is called outcomes research. You need to have a good data base.

We developed a proposal. We worked on it with the new administration, the Clinton administration's Health and Human Services. They signed off on it. We have groups from the ACLU to the AMA, the American Medical Association, American Hospital Association, and all the major data information groups which had come together on a good bill, and it was included in the Finance bill. It was included in the Labor bill. It was included in the first Clinton-Mitchell bill. But it got dropped out in the second Clinton-Mitchell bill. And that is part of the problem.

I was on a talk show in Missouri this weekend and one of the callers said, "Why are you saying you do not know what is in health care? You have been working on health care for over a year."

My answer on that is we have been working on health care a lot longer than that but we have had a different 1,400-plus-page amendment put in about every 3 or 4 days. And there was a third version that came out this Friday.

As we are talking about it, we are reading it and trying to find out what goes into it. I think it is important for us to look at some of the problems in the current amendment by the majority leader that he would have us substitute for the Finance Committee bill. And with apologies to the people who were on late nights, we just picked 10 reasons why, back at the home office in my State, the Mitchell bill should not be approved—the amendment by the majority leader.

First, starting out with No. 10, "Government-mandated purchasing groups are back." This was a feature of the original Clinton bill. They were called HIPC's, Health Insurance Purchasing Cooperatives. HIPC's became one of the first things that the public focused on, that is, a Government-designated purchasing organization. Every State that had talked about having a mandated or a Government-run purchasing cooperative, a HIPC, moved away from it. The American people moved away from it as we discussed the original proposal by President Clinton. They looked like they were dead; however, they have come back. They have come back in a new form.

The Government will now designate its official HIPC in every region of the country. It will designate an existing purchasing cooperative as one of its HIPC's. And every employer in that area will have to designate one. It puts the Government-run purchasing group at the head of the line and it gives them the power to run the health care market as a bureaucracy. There is no option for the businesses, the employers in that area. They have to offer it.

When they were first proposed the American people said, "No, we don't want them. You would either have a choice between a State-run store or a private enterprise operation, and we have found in this country that the private operations are the ones that provide the best service at the best price."

Reason No. 9, the plaintiffs' attorneys, the trial lawyers, will love it. Because there are, shot through this bill, all kinds of incentives for people to sue their health plan. This creates a new private cause of action on which we could award damages if the plan does anything that would deprive anyone or tend to deprive anyone of health care or adversely affected access to health care services. This is a tremendous expansion of the civil rights measures. We worked very hard and passed a civil rights law a couple of years ago. This includes, in the new amendment which is offered by the majority leader, a whole range of new remedies and new causes of action for the attorneys who want to bring suits.

We need real malpractice reform, not the encouragement of new suits. You can sue your health plan. The Attorney General can bring suits against health plans. And a recipient, a citizen, gets new grounds even to sue the State if they are not happy with the way the State operates.

The Congressional Budget Office, in analyzing the first Mitchell plan, says that the plan would have great incentives for people to sue the health care providers. It says that it would offer significant encouragements to lawsuits that would be disruptive and that would have an adverse impact on costs, because the litigation costs would wind up being passed along to the others who are participating in the system.

Reason No. 8, the States are given 177 new responsibilities and there are no grants for the States. If the States do not run the program the way the Federal Government wants it, they can take over the State programs. That is bad enough, but if this takeover occurs any time after January 1, 1997, then the Federal Government comes into that State and imposes a 15-percent surtax on all premiums. So that if a State does not like the way it is being told by the Federal Government to run it, the Federal Government has the ultimate club. The Federal Government takes over and the Secretary of Health and Human Services has the option to run it and impose a 15-percent surtax, driving up the cost of insurance to the people in the State.

Again, the Congressional Budget Office says that the difficulties facing the States would be tremendously high.

On page 11 of the Congressional Budget Office report, it states:

> The States have to certify standard health plans and health insurance purchasing cooperatives, establish separate guarantee funds for community rating and self-insured health plans, monitor variations in the marketing fees of HIPC's and other systems for purchasing insurance, and ensure carriers meet minimum capital standards.

These standards are largely federally determined, and the CBO said:

> It is doubtful that all States could develop the capabilities to perform these functions effectively in the near future.

They go on to say in the system of subsidies, again quoting from page 11:

> Integrating these three subsidies in a sensible and administrable fashion would be extremely difficult especially as some families could receive subsidies from more than one program.

And they point out several kinds of subsidies that would be very difficult to integrate.

This, to me, seems like an open invitation to have the Federal Government take over the State responsibilities and move even more directly into the job of running and controlling health care in our Nation.

Reason No. 7: Health care insurance premiums will skyrocket for young families. My colleagues, and those who have been following health care reform that has been implemented around this country, know that a real problem has arisen in New York because New York says everybody is going to pay the same insurance premium under their community-rating system, regardless of their age.

The fact is that those of us who are older require more health care coverage than those who are younger. Typically in this country, as people get older, their incomes go up, so they are better able to afford that higher cost health insurance. But to go to strict community rating without age adjustment means that young families just getting started with small children and the burdens of starting a family will have to pay a subsidy in their health insurance program for their parents and for others in their parents' generation who, because of their age, simply have higher health care costs.

We already have burdens on the working young today. They have to pay for the Social Security, they have to pay for Medicare for the seniors, and now there is going to be a windfall for the older wealthy who will be able to take advantage of the lower health care costs of the younger while the younger people are paying more in their premiums to take into account the fact that everybody has to be charged the same premium regardless of age.

That simply does not make sense. That is the one reason that is driving the New York system to force younger people out of the plan. It is moving away from universal coverage.

Reason No. 6: There are 50 new bureaucracies created in the Mitchell bill. I am not going to list all 50 here. But let me give you some of the most interesting.

There is a Government health insurance purchasing cooperative; a National Health Benefits Board; a National Council on Graduate and Medical Education, and I believe the chairman of the Finance Committee, the distinguished senior Senator from New York, has pointed out that the Federal Government would use that body to determine what kind of degrees students at medical schools should receive, a very frightening prospect if you have followed the record of other Government agencies in predicting what various professions are going to need in the future.

There is a National Council on Graduate Nurse Training; a National Advisory Board on Health Care Work Force Developments; there is the United States-Mexico Border Health Commission; there is a State Compliant Review Office; there is a Commission on Worker's Compensation Medical Services; and there is a National Health Care Cost and Coverage Commission.

I do not believe we need more bureaucracies. We do not need 50 new bureaucracies. We need to fix what is wrong with health care, not create 50 new positions from which problems can arise in health care.

Reason No. 5: Employer mandates will cost jobs. We have talked about that before. The Clinton plan went directly to employer mandates. Everybody knows that when you force a new cost on a business, there are several things that can happen: Either wages can go down or profits can go down, or, most likely, wages will either go down or people will be laid off.

Under the Clinton-Mitchell plan, there is a trigger. If you do not reach 95 percent by the year 2000, then either Congress acts or an employer mandate and an individual mandate are triggered into effect in that State. It is not just a burden on the employer; it is a requirement that you, the individual, have to get insurance. The combination of these, No. 1 sets up such a mixed scheme. The Congressional Budget Office thinks there is no way to implement a State-by-State trigger. Let me tell you what would happen.

If, for example, in my State, say Missouri was only at 94 percent—or it could happen in any other State; frankly, based on our experience, it might happen in most States—there would be a trigger and there would be a mandate that everybody in that State has to get insurance and employers would have the responsibility of providing 50 percent of their health care costs.

The Congressional Budget Office has pointed out that this is going to have a significant impact on employment. On page 17 of the Congressional Budget Office report on the Mitchell bill, it says:

> The imposition of the mandate would raise the cost of employing workers at firms that do not currently provide insurance. Economic theory and empirical research both imply most of this cost would be passed back over to workers in time in the form of lower take-home wages.

They go on to state that for people near the minimum wage, the likely outlook would be that they would lose their jobs or some of the employers could go out of business if, in fact, they were not able to pay those additional costs.

If that mandate went into effect in my State but not in surrounding States, it is quite likely that the jobs would move out of our State into other States, further worsening an economic problem. This happened, as we all know, during the last decade in the Massachusetts miracle, where Massachusetts came up with a delayed employer mandate. As it got close to the time, the economy was collapsing, implementation of the employer mandate was postponed again and again because everybody realized in Massachusetts that if they had an employer mandate and other States did not, the jobs would pick up and move to the other States.

Well, the people of Massachusetts imposed a remedy, a remedy I happen to believe was a sensible one. They elected a Republican Governor. But that, to me, is a recognition of the reality of employer mandates.

Hard triggers are imposed regardless of the economic or social stability in the State. These hard triggers are likely to create uncertainty and chill economic growth, and they are simply a way to go after an employer mandate and an individual mandate without having to vote for it. You can say, "Well, it is off in the future, so maybe I can get reelected before the people in my State feel the impact of the employer mandate and the burdens of the individual mandates, which would require major changes in the economy."

This hard trigger can produce irresistible demands for price controls, you can see workers being laid off—part- and full-time workers being laid off—delayed capital investment, hiring decisions and hiring of low-wage workers in a much less generous fashion.

Reason No. 4: This creates a new trillion-dollar Federal entitlement program. The total subsidies under the Clinton-Mitchell plans 1 and 2—and we have not had a chance to analyze fully the Clinton-Mitchell No. 3 to see if there are any changes in it—but under the first two, the subsidies in the entitlement plan would cost over $1 trillion over 8 years.

This is a new entitlement of subsidies for low-income people to purchase health insurance. It is likely that they will be overly expensive, and as we have seen time and time again in other entitlement programs, they tend to cost far more than we expected they would cost. That is why we have an entitlement reform commission headed by the distinguished junior Senator from Nebraska and the senior Senator from my State, Senator BOB KERREY and Senator JACK DANFORTH, who are warning us in this country that we are about to destroy our economic future, bankrupt the Federal Government, and put our children and grandchildren in a trick box that they can never get out of. That is by reason of the entitlements that grow like Topsy, and even worse. This is, I believe, a very frightening aspect of the Clinton-Mitchell bills 1, 2, and 3.

No. 3, moving down to this line, this new bill—if I recall, President Clinton said, when he introduced his tax bill in 1993, that health care reform will save $300 billion over 5 years—results in $285 billion additional spending on health care in the future.

One of the reasons we got into the health care debate was to get costs under control. Now, we have all heard, and we talked about—and I agree with the statements here—the problems with people who do not have health insurance and the tragedies of people who have been denied health insurance when they or someone in their family have had a serious illness.

That is something we have to remedy, but let us not forget the other side of the equation. We got into this health care reform debate because Medicare and Medicaid were eating the budget of the Federal Government, Medicaid was

eating up State budgets, and health care costs were hitting businesses and the self-employed and retired people across this country.

The costs of health care are going out of control. That is why President Clinton as a candidate endorsed managed competition, because where we have seen some success in getting health care costs under control is through the use of market-based competition. It can work and it will work. But we cannot afford another $285 billion of spending.

Let me go back to what the Congressional Budget Office said about the spending. It says that there are going to be extremely high costs. They would have to be paid by taxes, a tax on high-cost health care plans. They are going to have a very complex system of generating the taxes and determining how much they cost. The expenses of the plan could be expected to grow with assessments, and such assessments would increase premiums, and in addition to costing more would discourage participation during the voluntary period.

In the analysis by CBO, they say there ought to be a tax cap, with which I agree, on the tax deductibility to get costs under control rather than having new spending built into the plan.

Reason No. 2—and this one is of concern to me because this one was in the original Clinton bill, as well as in this one—after the mandate clicks in, you do not have to pay your premiums. After the employer mandates, there are provisions in the bill that encourage freeloaders not to pay for coverage. Health plans cannot cancel health coverage for anyone who does not pay their insurance bill. That means once you go to a mandate, why bother to pay? Who pays? Well, the Mitchell bill imposes a collection shortfall add-on on honest workers and families to pay for freeloaders in the system. Now, freeloaders could get by with not paying their premiums and automatically passing on the payments to their honest neighbors.

Guess what happens? Honest neighbors will not be able to pay either. And then we get somewhere I expect to get—Government running the whole system.

That is one of the outcomes that I think is outrageous. It would not affect the low-income individuals for whom we are going to provide a 100-percent subsidy for their premiums if they are at poverty level or below. It would affect the working middle class. And those who are dishonest or wanting to shirk their duties and stick the bill on their neighbors just would not pay, driving the cost up to where everybody would be forced out of the payment of premiums because they would go through the ceiling.

Well, the first and best reason I think that the Mitchell bill will not fly is that it is longer than the Clinton bill. This latest volume is 1,443 pages long. I have talked about just a few of the problems in this bill. Every time we get a new version, we find new problems.

This is a bill which contains so much we do not need that I believe we should start afresh and work with something that has either been passed by the committees so every provision has had a chance to be fully aired or we ought to adopt a shorter substitute. With all the bureaucracies, with all the taxes, with all the mandates on the States, there are too many things bad about this bill.

I still believe, however, that we need health care reform in this country. I think the stage has been set. As I mentioned earlier, I have been working at Senator DOLE's direction on the health care task force with Senator CHAFEE and many of my colleagues for over 4 years. Week after week, we looked at what was wrong with health care and developed reasons and ways of improving the health care system. During that time, we fought battles with the Bush administration to try to get them to move forward with health care. Frankly, they did not do it, and I commend the President and Mrs. Clinton for making health care reform a priority because I think there are things that need to be done.

We need to make sure that people do not lose their health care if they get sick. We need to make sure that those who cannot afford it now can get resources to get health care. We need to cut down on expensive malpractice costs. But most of all, we need to get the system under the control that the marketplace will accomplish for us. We have lost track, when we are considering a 1,400-page bill, of doing the things that need to be done and not doing others.

I have been told by person after person in my home State of Missouri, as I have been back and talked and listened to them for the last several months: We do not want a Government bureaucracy running health care. Sure, we would like to see changes in health care, but do not hurt it. We do not want a system that does more harm. We do not want to see ill-considered, extensive, bureaucratic, overreaching Federal legislation.

The first principle of medicine is do no harm. In politics, the first principle ought to be if it is not broke, do not fix it. Well, I think that these 1,400-plus pages fix far more than is broken.

I believe the American people want us to have a bipartisan plan. I think they want to have something in which every American can have confidence. They want to have something with which they can go forward and say this has been fully considered and we have a good, sound basis for health care reform.

We have heard from the White House that, well, maybe it would be enough just to get a bill through here with 51 votes. Then they can take it to conference and no telling what will happen. As has already been pointed out on this floor, if we are going to make major changes in a program that affects every one of us and consumes one-seventh of our national economy, our gross domestic product, we better do it with broad bipartisan agreement so that the people of America can know that they are getting something that has been fully considered, fully aired, and has the best interests of the people of America at heart.

First, we need to get everyone into the system. We know that there are about 39 million people uninsured in this country today. If we are going to make sure that everyone gets into the system, we need to know who these people are. Who are the uninsured? Most of the uninsured are working adults—57 percent. There are 25 percent of them who are uninsured children, and the unemployed are 18 percent. Most of the uninsured are in families headed by a worker—84 percent. Perhaps most revealing is that most of the uninsured are farm families headed by a worker employed continuously throughout the year—never unemployed. That is 60 percent.

In fact, the largest segment of uninsured live in families headed by a full-time worker. Where do the working uninsured work? Well, most of them work in the retail trade, the services industry, or other areas. You have 7 percent in government, 18 percent in services, 23 percent are self-employed, 26 percent in retail, 32 percent in construction, and 46 percent in agriculture.

We need to eliminate barriers. First, we have to make sure that people are treated fairly under the tax laws. Most of the people in agriculture are farm families.

I listened to farm families throughout Missouri say, "Why don't we get to deduct 25 percent of our health insurance premiums? That is not fair." And I agree. Somebody working with a very wealthy corporation can have unlimited benefits, tax free to the employee and tax deductible by the employer. But the farmer and his or her family only get to deduct 25 percent. That is why the figures are so high in agriculture. That is a disincentive. That is a glitch in our tax system that we have to deal with.

People in the retail trade, if they work for a retailer—and the average profit margin for the retail employee in the country today is $1,700—if the employer does not provide health insurance, then the employee working full time in a retail establishment has to pay 100 percent—no tax deduction.

So the Tax Code itself causes, as some have estimated, as many as 9 million people to be uninsured.

Then next we would go to Federal subsidies to purchase insurance. Generally the subsidies that have been

agreed on by a Republican and Democratic basis alike are from 100 percent of subsidy and 100 percent of poverty phasing out at 150 percent to 200 percent to 240 percent. This is a major undertaking by the Federal Government. This is something we have to pay for. But this is to make sure that no one is denied health access and health services because they cannot afford the insurance.

Once they get it, however—and one of the things that scares many people is that they will lose their health care insurance once they have it.

I have heard of too many problems, too many tragedies of families who thought they had good insurance policies, and, if they had a major, catastrophic illness to a parent or even to a child, they have found their health insurance canceled or their premiums jacked up through the roof. We cannot accept that. I think everybody in this body, on each side of the aisle, would agree that the time has come to stop that practice.

Health insurance reform ought to ensure that health insurance spreads the risk, not allow a sharp, practicing company to come in and cherry pick off very low premiums to healthy people, then throw them out, and somebody that they covered gets sick. This, to me, does not make sense.

The next major goal of health care reform is to contain costs. I believe that the marketplace will work. We have seen where groups of employers or groups in a community get together to purchase health care insurance. They have the information. They go to health care providers and get information on the quality and cost of care. They can make a tremendous difference in the cost of insurance.

I talked with people who are working in a small purchasing cooperative through a third party administrator in Springfield, MO. Some of them have been in the program for 7 years, and they find their health care costs are still what they were 7 years ago. They have not come back up to that height because they are exercising the discipline of the marketplace. It is the discipline of the marketplace that gives us the best standard of living in the world, whether it be for food, clothing, or anything else you want. It has made a success out of the rest of our economy. The reason that marketplace competition has not worked in the United States is because there have been impediments, first dollar coverage which takes away any incentive to purchase health care services wisely and at the best cost.

I believe we need more managed competition, not more Government bureaucracy. I believe that the Mitchell bill is Government run amok, with all the bureaucracies, with millions and millions of dollars in new spending only marginally relevant to the urgent health care needs of our Nation.

Here are just a few:

There is $50 million per year for school-based health education. I believe health education is important. But I believe that local communities and local school boards should decide upon the curriculum and fund the program, not the Federal Government.

There is $82 million a year for school-based services. The idea is to get the children into health care services so they are covered by a health plan.

We do not need to be paying more money for school-based services from the Federal Government. The Federal Government is going broke rapidly. Let us not start piling more expensive programs on it.

There is $200 million per year for the Department of Labor to retrain and deploy displaced health care workers.

We thought that when the Clinton bill was initially proposed, that there would not be any displacement or dislocation. In addition, there are about 154 different training programs in any event. So why do we need more training programs.

There is $92 million a year for OSHA, the Occupational Safety and Health Administration. A new program entitled "Occupational Injury and Illness Prevention." I thought that was the job of the agency already. What are we funding it for? Why do they need another $92 million?

Let us take these new spending programs out, consider them separately, and if they are really needed, if we need to tell OSHA what it is supposed to prevent, occupational illness and injury prevention, let us cut out some of the money we are now providing OSHA, and tell them you ought to be preventing occupational illness and injury. That seems to be what the agency was all about. I would like to see them go back and do that job.

Another problem is that it makes the women, infants and children spending program mandatory. It becomes an entitlement program. I support the women, infants and children, the WIC program, and have backed efforts in the Agriculture Appropriations Subcommittee to move the program towards full funding. Why do we set it up as a new entitlement that is called an entitlement which would join the others in growing without control, without legislative oversight?

I believe we need reform that puts Americans, not politics, first. I am committed to working to get a bill on this Senate floor that will do the job and that will do it right. We cannot walk away from families who desperately need relief from insurance company cherry picking. They need affordable coverage, and they should not have to wait as we fuss about the Government bureaucracy bill. We need to have both sides working together.

I think there is a lot we can agree on. I think we could get a solid majority in this body, and I would hope the other body would follow us—to say that these are the things that are wrong. Let us do what really is necessary, and what is pressing now. But let us throw the baggage overboard. There are too many burdens. There are too many costs. There are too many taxes. There are too many mandates. This Clinton-Mitchell bill in any of its transmogrifications from 1 to 2 to 3 is a far bigger bite than we can or should bite off because I do not intend to vote for a bill that would harm the health care system, that would further burden our Government, and that would put the people of American at the dependence of the Federal Government to get health care.

This is an effort to put big Government first. We do not need that. I think there are key features that a majority agree are essential to achieve real health care reform. I will work for a bill that includes those and leaves the rest out.

First, fair tax treatment for the self-employed and uninsured.

Second, insurance market reforms to ensure you do not lose your health care coverage or your insurance, or have your premiums escalated if you get sick or lose your job.

Third, provide subsidies for low-income individuals not covered by health care now.

Fourth, real malpractice reform.

I commend the majority leader because between transmogrification one and two, he knocked out a provision that would have preempted all State malpractice reform laws. The State of Missouri and the State of California have gone a long way. First, they were going to repeal all of the State laws. We do not need that. We need real malpractice reform.

Fifth, we need to move toward electronic filing of health care claims, information with privacy protection, security protections to the individuals, so their health information is not disclosed. We need electronic filing to lower costs, to provide better information on the effectiveness of health care procedures. I hope we can go back to the provision that, along with Senator RIEGLE in this body and with a bipartisan cosponsorship in the House, we have already worked on.

Finally, I believe that we need to rely on the market competition to keep health care costs under control.

Madam President, I believe these are the outlines of a bill we can pursue, and we can achieve great things. I will continue to work with my colleagues on both sides of the aisle. We do not need 1,400 pages of bureaucracy. We do need real health care reform. I stand ready to work with my colleagues to achieve it.

I reserve the remainder of my time.

Mr. HATCH addressed the Chair.

The PRESIDING OFFICER. The Senator from Utah [Mr. HATCH] is recognized.

Mr. HATCH. I ask unanimous consent to speak as in morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

THE CRIME BILL

Mr. HATCH. Madam President, the most apt comment one can make about President Clinton on the crime bill is: There he goes again. Instead of taking up the good faith offer of myself and other Republican leaders to meet and negotiate a truly bipartisan, truly tough crime bill, he is playing the same old inside-the-beltway partisan blame game. The people of Utah and across the Nation will not benefit from the President's partisan tactics.

It is time for the news media to expose some myths in this crime debate.

First, President Clinton has not exerted leadership on this issue. He has exalted rhetoric over leadership. He has never submitted a remotely comprehensive crime bill to Congress. Indeed, his administration sat largely on the sidelines during the Senate's consideration of a crime bill last year.

Second, the Clinton administration is promoting the phony line that the crime bill emerging from conference had already received majority support in both Houses and that opposition to it is mere politics. In fact, the bill that I voted for and which passed the Senate 94 to 4 in November did not contain the $1.8 billion for the so-called Local Partnership Act, and open-ended social spending boondoggle which slaps an anticrime label on a liberal, 1960's-style Great Society Program. The money in this pork program can be spent on education to prevent crime, job programs to prevent crime, and drug treatment to prevent crime. What we need to prevent crime, however, is more support for local, State, and Federal law enforcement and more prison space.

The Senate bill I supported last November did not have $900 million in yet another job training program. What we need in the fight against crime is not to spend this $900 million on yet more job training, but to spend it on building new prison space.

The Senate bill I supported in November did not contain the $895 million Model Intensive Grant Program, which would spend precious crime fighting resources on transportation, public facilities, and yet more job programs. The conference report contains all of these social spending boondoggles.

The bill I supported in November did not provide for the release of as many as 10,000 or even 16,000 Federal convicts, many of whom are going to commit more crimes when they would otherwise be in Federal prison. The conference report supported by President Clinton provides for such early release. This is unconscionable. Yet, it has been ignored by the pundits.

The bill I voted for in November contained numerous tough provisions dropped in conference. For example:

Tough Federal penalties for violent juvenile gang offenses, the Dole-Hatch-Brown provision—dropped.

The Moseley-Braun-Hatch provision for mandatory prosecution for violent juveniles age 13 or older as adults in appropriate cases—dropped.

Tough mandatory minimum sentences for using a firearm in the commission of a crime, the D'Amato provision—dropped.

Mandatory minimum sentences for selling drugs to minors or employing minors in a drug crime, the Gramm provision—dropped.

Amending the rules of evidence to allow evidence of prior offenses of rape and child abuse in prosecutions for those offenses in appropriate cases, the Dole provision—dropped.

Allowing the notification of communities that a convicted sexually violent predator has been released into their midst, the Gorton provision—dropped.

Requiring mandatory restitution to victims of violent crime, the Nickles provision—dropped.

HIV testing of accused rapists, the Hatch provision—dropped.

Ensuring the swift removal of alien terrorists without disclosing national security secrets in the deportation process, the Smith-Simpson provision—dropped.

Ensuring that criminal aliens are swiftly deported after they have served their sentences, the Simpson provision—dropped.

The crime bill conference report, I might add, is not the same bill that emerged from the other body either. As one example, the bill sent to us by the other body contained $13.5 billion, at least ostensibly for prisons, compared to the conference report's $6.5 billion.

So it is time for the new media to call this administration's bluff and set the record straight—this crime conference bill is not the same bill either House sent into conference.

Let me turn to a third myth fostered by this administration and its congressional allies—that this bill contains billions for prisons. Nonsense. Not one dime in the bill the President supports must be spent on building one prison cell.

The other side of the aisle claims to spend $8.3 billion on prisons. Yet, $1.8 billion of that funding is simply to reimburse States for costs associated with incarceration of criminal aliens—funding that will go overwhelmingly to only a handful of States in any event.

The remaining $6.5 billion in so-called prison spending is in the misleadingly rugged-sounding program entitled "Violent Offender Incarceration and Truth in Sentencing Grants" section. Yet, not one dime of this money has to be spent on the construction or operation of prisons. The pundits should read that section and stop repeating this administration's misleading rhetoric about it. I say it again, not one dime of the so-called prison provision of the bill supported by the President must be spent on prison construction or operation.

Rather, the money can be spent on programs, including alternative confinement facilities and drug treatment, intended to free up existing prison space—not to build new prisons. These programs will ostensibly free up existing prison space through early release-type programs for some criminals, half-way houses for still other criminals, and similar alternatives to prison. This administration is hostile to a real buildup in new prison space. They do not really believe in new prisons—they believe in rehabilitation, job training, drug and sex offender treatment, and softer sanctions as alternatives to prisons. The American people know better: The best way to prevent crime is not to coddle criminals but lock them up for a long time.

Indeed, the so-called prisons section of the conference report requires States, as a condition to receiving any of this so-called prison money, to implement a "comprehensive correctional plan." The plan must include, among other things, "diversion programs, particularly drug diversion programs * * * prisoner rehabilitation and treatment programs, prisoner work activities, and job skills programs." What do any of these things have to do with locking up violent criminals?

In effect, in order for the States to qualify for the so-called prison grants, they have to spend much or all of it on a costly, liberal corrections scheme backed by the President. This is a shell game. And it is a waste of money that ought to be spent on the construction and operation of something this administration seems to feel is old-fashioned—bricks and mortar for prisons.

Myth No. 4: This conference report contains tough truth-in-sentencing requirements. Supporters of this bill claim it conditions 40 percent of the so-called prison grant funding on State implementation of truth-in-sentencing. The provision is a sham. State adoption of a determinate sentencing scheme will only apply to second-time violent offenders. Moreover, these grants are subject to the same condition I mentioned earlier—the State must implement a liberal corrections policy.

Myth No. 5: The conference report contains a tough three strikes and you're out. It does not. The impact of any such provision is directly related to the scope of its qualifying convictions. The conference report's provision is far too narrow, affecting as few as 500 cases a year.

The Senate-passed crime bill, on the other hand, contained a broad approach to dealing with recidivist, violent

criminals. In fact, the Senate-passed bill provided mandatory life imprisonment for two-time losers who sell drugs to children, employ children in the drug trade, or who commit murder. But that was too tough for this administration, and it was dropped in conference. The Senate bill, which federalizes crimes committed with a firearm, would subject thousands of three-time violent offenders and drug traffickers to life imprisonment. But this was too tough for this administration, and it was dropped in conference.

Myth No. 6: The crime conference report is going to put 100,000 new police officers on the street. In the spirit of bipartisanship, Republicans have supported spending the money the administration's own analysis says would result in putting all of these new police officers on the street. But, frankly, independent analysts scoff at the administration's claims.

For example, consider the remarks of John Dilulio, professor of politics and public affairs at Princeton University, director of the Brookings Center for Public Management in Washington, DC, and self-described card carrying Democrat. He said, on August 8,

> The bill calls for 100,000 new cops. But when you read the relevant titles of the bill, what you discover is that that really means about 20,000 fully funded positions. And if you're stouthearted enough to look at this bill in light of the relevant academic literature, you know that it takes about 10 police officers to put the equivalent of one police officer on the streets around the clock. This is factoring in everything from sick leave and disabilities to vacations and three shifts a day to desk work and so on. So that 20,000 funded positions becomes 2,000 around-the-clock cops. And 2,000 around-the-clock cops gets distributed over at least 200 jurisdictions for an average of about 10 cops per city.

Indeed, Madam President, the irony of the other side of the aisle claiming that opposition to this conference report is political is this: President Clinton has treated this issue largely in a political way. He claims he will put 100,000 police officers on the street, which will sound good in 1996, but this bill will not produce anything close to that number of new police on the street by 1996 or 2006. He claims he backs the death penalty, but he apparently has cut a deal with death penalty opponents to implement unilaterally the concept of the so-called Racial Justice Act, which will end the death penalty. He claims he backs a three-time loser provision, but endorses a very weak version of such a law. In order to satisfy the liberal social spending interests in his party, he has endorsed squandering of billions of dollars in scarce crime-fighting resources to be spent, instead, on liberal social spending pork.

Madam President, again, I call upon President Clinton to meet with Republicans on this matter. We can get a good crime bill to his desk. But that bill must be a bipartisan bill, not one which merely tinkers with the conference report, and not one which only satisfies the liberal wing of his party.

HEALTH SECURITY ACT

The Senate continued with the consideration of the bill.

Mr. DASCHLE addressed the Chair.

The PRESIDING OFFICER. The Senator from South Dakota.

Mr. DASCHLE. Madam President, I ask unanimous consent that Lucia Giudici and Jeffery Geller, congressional fellows of my office, be granted floor privileges during the consideration of S. 2351.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. DASCHLE. Madam President, I yield such time as he may consume to the distinguished Senator from Massachusetts, Senator KENNEDY.

The PRESIDING OFFICER. The Senator from Massachusetts is recognized.

Mr. KENNEDY. Thank you very much, Madam President. I have been listening over the course of the late morning and this afternoon to the various speeches about the Mitchell bill, and the Dole bill, and some general expressions of concern, particularly with regard to children.

It is important for the American people to understand that this is the third day that we have been debating the Dodd amendment, of which I am proud to be a cosponsor, to accelerate protections for preventive services for children in this country, up to 1995.

We have been trying to get the Senate to go on record to approve this particular measure, which is of such incredible importance to children in this country. I spoke earlier in the debate about the importance of Senator DODD's amendment, as did Senator RIEGLE, who offered a similar amendment to the Finance Committee bill, which was approved with bipartisan support. The Senator from Illinois, and a number of other Members also spoke in favor of this measure.

But we are trying now, in our third day, to come to a decision. Those who have put forward this amendment—which is not very complicated and is supported by a number of insurance companies—feel that we must build on the protections for children established in the Mitchell bill. If we are going to have a bill—and I believe we will have a bill—we ought to give priority to children, for all the reasons outlined in the earlier discussion.

But we are now in the early afternoon of the third day, and many of us would like to see a resolution of this matter, so that we can move on to other proposals to strengthen the Mitchell bill. Senator HARKIN has a proposal with regard to disability issues, which I think makes a great deal of sense. It will be cost effective and responsive to some of the very special needs of persons with disabilities. There will be other amendments to strengthen the bill that deal with rural health needs and mental health provisions.

In the brief discussion last week between Senator DOMENICI, Senator MOYNIHAN, myself and others, we talked about various provisions in this legislation dealing with mental health. The issue is parity of coverage for individuals with physical health care needs and mental health care needs.

We are eager to debate all these issues and to permit the Senate to go on record on these matters. Nonetheless, 3 days into the debate we are still discussing the first amendment. There are those who say "We are not trying to stall this proposal," and yet we cannot come to grips with something that is as basic, as fundamental as the amendment that is before us, which would improve coverage for the 12 million children who do not have coverage under Medicaid or through a working parent's health insurance policy.

The number of children without insurance is growing year after year after year. The Carnegie Commission estimates that by the year 2000 about half of all of the children in the country will not be covered by a parent's employment-based health insurance policy. We are talking about working parents, men and women who are playing by the rules, working 40 hours a week, 52 weeks a year, trying to provide for themselves and their families.

All this amendment does is say that beginning next year insurance policies are going to cover a range of preventive health care services for children. Contrary to what we heard from some of our colleagues, this amendment is not about subsidies. It is a very simple proposal that ensures that beginning in 1995 private insurance policies will provide preventive health care services for children.

That is what we would like to see the Senate decide this afternoon. I imagine we will have a chance this afternoon to talk about some of the other principal differences between the Mitchell bill and the Dole bill. We will discuss not only how these bills affect children but how they affect working families and senior citizens. The Dole proposal does not provide prescription drug coverage or home and community-based long term care services for our seniors, as the Mitchell bill does.

We are hearing the voices on the Senate floor saying that they care about the elderly and they care about prescription drugs. One bill covers it and the other bill does not.

We hear Members saying they care about community-based long term care services so that seniors are able, as a matter of choice, to remain home and get the health care services and support they need. Seniors may want to be

able to receive community-based long term care services during the day, and then return home to receive the care, affection, and love of the members of their family. There are provisions in the Mitchell bill to provide these services to seniors and the disabled. There are no such provisions in the Dole bill.

I will take just a few moments to review once again why this particular amendment is important.

First of all, I will take a moment to describe the difference between the Mitchell proposal and the Dole proposal when it comes to protecting children. Families with income below 100 percent of poverty would be protected under either proposal. However, for a family with income at 150 percent of the poverty level, which is $22,000 for a family of four, you see that under the Dole proposal the family would have to pay $5,883 to provide insurance for their children, while under the Mitchell proposal the same family would receive a full subsidy to buy a health insurance policy for their children. We can see that the Mitchell bill targets subsidies to provide coverage for children. Working families earning $29,000 per year would have to pay only $232 for coverage for their children under the Mitchell bill, compared to $5,883 under the Dole bill. Families earning 250 percent of poverty, or $37,000 would be able to provide coverage for their children at a cost of only 2.7 percent of their income, compared to 15.9 percent under the Dole bill. For working families that want to provide insurance for their children, the cost is virtually prohibitive under the Dole bill, and that is unfortunate.

Mr. President, we have seen also in recent times that the percentage of children who are being covered by Medicaid has been increasing for the past several years. So we have a phenomenon where of more and more children are falling into the Medicaid Program. That is certainly better than no coverage at all. However, the percentage of children being covered by their working parents is going down, and the percentage with no insurance at all is increasing every year.

The majority of uninsured children, as I pointed out earlier, are from working families. I can not overstate the importance of providing preventive services for these children, and for all children. The Mitchell bill provides these necessary services for children without deductibles or copayments. Under the Dole bill, we can not be sure that preventive services for children will be available without copayments or deductibles. The Mitchell bill also provides vision care, dental care, and hearing care for children. Under the Dole bill, we can not be sure whether these services will be available to children.

We heard from our colleagues recently that they support the WIC Program, but they do not believe necessarily believe that we ought to fully fund the WIC Program. The WIC Program helps ensure that children will get the nutritious food they need to develop and grow. And yet some of our colleagues do not want to provide adequate funding for this program, which helps keep children healthy.

We heard one of our colleagues earlier in the day talk about the need for school-based health clinics that are to be developed with input from parents, school officials, and teachers. In the areas where they have been developed, this is enormous support for these clinics.

We passed this provision in our committee 17 to nothing. We had Republican support for it. We worked with our Republican friends who recognized the importance of making sure that we address the needs of America's children. We need to provide assistance not only to parents, but also to children, in the form of school-based health clinics, which can make such a difference in improving the health of children.

When you read through the Carnegie Commission report and other reports, you read about the problems facing many schoolchildren today. Many are suffering from hunger and malnutrition, and many have to deal with problems at home such as spousal abuse, or other violence or substance abuse. When a child is sick, many times a working parent can not stay home to care for the child. If a parent can not afford to pay someone to look after the sick child, the parent must send the child off to school. The child not only does not learn, but in many instances may pose a health threat to other children. School-based health clinics can make an important difference not only for the sick child, but also for his or her classmates.

The difference between how the Mitchell bill and the Dole bill treat children and families is quite apparent from that chart. You can see the difference in the cost to families that want to provide insurance for their children. Many families simply can not afford to pay 13, 15, 19, or even 26 percent of their income to provide insurance for their children.

Then if you go even beyond just the special program to provide coverage for children, you can see that the Mitchell proposal, which assumes shared responsibility at some point in the future, makes insurance coverage much more affordable for families than the Dole proposal, based on CBO estimates of the premiums.

The chart shows that families with income from at 125 percent of poverty pay only about 4 percent of income for family coverage under the Mitchell bill, compared to 12.7 percent under the Dole bill. Under the Dole proposal working families would be forced to pay 3 or 4 times as much as under the Mitchell bill.

And we can listen to our colleagues talk about how their proposal is going to deal with and solve the kinds of problems that the Mitchell program addresses, but the Dole approach it is just unrealistic. It is absolutely unrealistic to think that families will be able to afford coverage under the Dole proposal. Sure they will be able under the Dole proposal to participate in a health care program and a health care system, but this is what they are going to have to pay.

And does that really improve on the current situation for most families? In theory everyone has health care available to them today, but many people cannot afford it, and most of them will not be able to afford it under the Dole proposal either.

So, Madam President, just very briefly on this, I am hopeful that we will be able to get to a resolution this afternoon on the issue of the children's amendment. I hope we will also be able, as we move on through, to talk about how the different bills treat working families. This chart indicates at least what the cost of coverage would be for working families. We also must discuss the comparison between how the Dole and Mitchell bills treat senior citizens.

We must include a comprehensive program that to improve coverage for our seniors. We have studied that issue enough. We have the excellent bipartisan Pepper Commission report that made a series of recommendations. Some of those recommendations have been adopted in the Mitchell proposal, including additional asset protection to ensure that seniors will not be wiped out with an extraordinary, sudden illness that would basically swallow all of their savings.

There are also provisions in the Mitchell bill to ensure the integrity of the insurance programs that many individuals, the seniors, participate in. We find extraordinary facts that many of the long-term care insurance programs for our elderly, are not available to those who need them.

We have standards that have been established. I must say, those standards were worked out a year ago in a bipartisan way and have been included in this legislation. Senator HATCH and I reported it out of our committee. It is very, very important in terms of protecting those seniors who do have long-term health care needs.

We have important features. One, we have an asset protection for our seniors in the Mitchell bill, which the Dole bill does not provide. Second, we have the preservation of the integrity of the long-term insurance, which the Dole bill does not provide. Third, we have the prescription drug proposals that will be fully implemented by the year 1999. And beyond that, you have the home- and community-based long-term care program, which is phased in to help assist our elderly and disabled.

These are all very solid, responsible programs.

In each of these areas, we find a difference of approach between the Dole bill and the Mitchell bill.

So we are very hopeful, Madam President, that we will be able to have some early resolution of these particular amendments in an early way.

Madam President, I ask unanimous consent that certain staff members be able to have access to the floor during the consideration of this legislation. I send their names to the desk.

The PRESIDING OFFICER. Without objection, it is so ordered.

Who yields time?

Mr. DASCHLE. Madam President, I yield such time as he may consume to the distinguished Senator from Illinois.

The PRESIDING OFFICER. The Senator from Illinois is recognized.

Mr. SIMON. Madam President, I am pleased to speak again on this health coverage for all of our citizens.

We face now two choices: The proposal by Senator MITCHELL, the majority leader, that frankly is not as strong as I would like, but moves us in the right direction; and the bill proposed by the minority leader, that I think should be called the Insurance Industry and Tobacco Industry Protection Act, because that is what it does. It offers no taxes, no taxes whatsoever on tobacco, and it has a whole series of loopholes that are designed specifically for the insurance industry.

Let us take a look at where we are in this country. It really is incredible, when you think of it. We join other industrial countries in providing health insurance protection for one group and one group alone—that is people who are in our prisons. If you are convicted of murder and you go to prison, you will get health protection in our country. But if you are someone who is struggling at a job that may be a minimum-wage job, working 40 hours a week, two countries do not protect you in the Western World—South Africa and the United States of America.

If you work in France, you are protected. If you work in Great Britain, you are protected. If you work in Japan, you are protected. If you work in Italy, you are protected. But in the United States of America, you are not protected. Every one of those other countries protects all children. We do not.

I fear that we may not do what is right in this country and, in the next few weeks, as we make the decision, I fear we will not do what the American people want us to do, and that is to protect all of our citizens.

We are also unfair to employers. If you were to start with a blank slate, Madam President, and say: Let us design a system where you can volunteer as an employer to protect your employees and if you volunteer then you can also pick up the tab for those who do not volunteer, we would say that is a ridiculous system. And yet, that is precisely the system that we have. And under the Dole proposal, we will continue to shift that burden.

It is very interesting, as you look at the series of proposals made by the minority leader. In his bill, he says, just as the Mitchell bill says, if you want to get the same protection that Senator MURRAY from Washington has, Senator CRAIG from Idaho has, Senator WELLSTONE from Minnesota, Senator REID from Nevada, Senator DASCHLE from South Dakota, or PAUL SIMON from Illinois, if you want to get the same protection we have in the Mitchell bill, you have a 1.5-percent administrative fee that insurance companies can collect for this cost. The Dole bill says you can do that, but there is a 15 percent administrative fee, 10 times as much. That is a pretty nice largess for the insurance companies.

The American public wants coverage. I have never seen a poll like the New York Times poll that says 79 percent of the American people say it is very important that we have universal coverage for all of our citizens; 17 percent say it is somewhat important. That is a total of 96 percent. Three percent say it is not important and 1 percent do not know. Madam President, 96 percent—I cannot think of another controversial issue in which 96 percent of the American people are on one side, properly so. And the question is whether we are going to respond.

The bill that came out of the Labor Committee which Senator KENNEDY chairs by bipartisan vote says we are going to cover everyone. We had special breaks in there for small businesses. Employers who now cover everyone would be better off, clearly, under that bill.

The Clinton bill calls for universal coverage. Both of them do not attain it as rapidly as I would like but they cover it. The Mitchell bill covers 95 percent by the year 2000. That is not as strong as I would like but at least it moves us in the right direction.

The Dole bill—we are now at 83 percent coverage, 17 percent of all Americans not covered. That means if there are 100 people in the gallery right now, 17 of them are not covered. I do not think you will find 17 people in the gallery who do not want to have health insurance coverage.

Last week my secretary went to dinner with two friends and during the course of the dinner one of the people at the dinner—some of my friends, at least on this side of the aisle, know her because she has helped raise funds, she is a fundraiser and has been a professional fundraiser—and she started to perspire and turn pale and had some of the symptoms of a heart attack. They wanted to take her to a hospital. But she said no, she could not go to a hospital. They then got in a cab to take her home and she had nausea in the cab on the way home. Fortunately it turned out she had food poisoning rather than a heart attack. But she did not have health insurance and she was afraid to go to the hospital.

(Mr. BYRD assumed the chair.)

Mr. SIMON. We should not have that in this country. Every American ought to be covered. If we pass the Dole bill, we are not only going to stay at the 17 percent, we are going to slip further. I want to see every citizen of West Virginia covered, Mr. President. I want to see every citizen of Illinois covered. If that means that we have to have a tobacco tax—I am speaking for myself now, not any Senators from West Virginia—if we have to have a tobacco tax, I am willing to vote for it. If we have to have a payroll tax, I am willing to vote for it. I know you cannot do this on the cheap. We have to pay for it. There is no free lunch. But we are paying for it in the worst possible way right now.

Mr. President, 14 percent of our national income is going for health care. No other nation on the face of the Earth spends that much. And 38 million Americans are left out.

I want all Americans to be covered. That is what the American people want and I hope we do the right thing in this body.

Mr. President, I yield the floor.

The PRESIDENT pro tempore. The Senator from Idaho [Mr. CRAIG].

Mr. CRAIG. Mr. President, I yield myself such time as I may consume.

The PRESIDENT pro tempore. The Senator is recognized for such time as he may consume.

Mr. CRAIG. Mr. President, for a good number of days now, the Senate has been engaged in what I have to believe and what I think most Senators believe to be probably the most valuable debate or at least the most important debate that we have been about in a good number of years.

We are debating S. 2351, better known as the Clinton-Mitchell health care proposal. While at this very moment the Dodd amendment is pending on the floor, the one thing that became very obvious to this side of the aisle, to Republicans, was that we were not going to be openly granted the opportunity to debate the Clinton bill in its entirety before we started the amendment process. So we found it very important to come to the floor and, as best we could, to not only debate the Dodd amendment but, more important, to discuss with our colleagues here in the Senate and the American people the Clinton-Mitchell health care proposal.

I say that because I think most Americans agree with me, this is probably the most important and substantive debate that has occurred on the floor of the U.S. Senate in a good number of years. Why? Because it affects every American in the most personal of ways. It affects whether he or

she, or they will be able to deliver to themselves or their families, the quality of health care that every American desires. That is the substance of this debate and that is why it is important and that is why it is more important that we are here today—not in the August recess—debating this issue.

So for the next few moments I would like to talk about the importance of that debate, talk some about the Clinton bill, but also to talk about a variety of other issues that I think spiral around this debate that certainly the citizens of Idaho have engaged me in over the course of the last several years and that I think are important.

This morning I attended a press conference with some citizens and business people and representatives of small businesses especially from the State of Hawaii. The reason I was with them was because they flew all night from Hawaii here to tell the American people in a press conference that the much-touted State-mandated health care plan in Hawaii is not what many have said it is, or that it has been ever since it was enacted in 1971.

The Governor of Hawaii was over, saying, my, this is a marvelous program and it just covers everybody. But State employees are exempt from it. Why are State employees exempt from it if it is such a wonderful program? The reason is because the State program is a better program. And that the employer-mandated program in Hawaii is causing great problems in the small business community today. You are finding a lot of employment that is part time simply because if it is over 20 hours a week, then it is full time, and the employer has to pay for the mandate.

So there are a lot of people working part time in Hawaii—maybe a great number of jobs—but not getting the kind of coverage because it is a mandated tax. It is a requirement if you are in business in Hawaii that you have to have this program. And if you have to have it, doggone it, the average human beings being what they are and trying to save a little money and oftentimes trying to just keep their business doors open are going to find a way around that kind of mandate, a legal way, if they can, so they can make ends meet so they can hire the people they can afford to hire. And that is an important issue that is embodied in the Clinton-Mitchell bill, and that is an employer mandate that a lot of people will be talking about over the course of the next several days that a good number of us are very concerned about.

Whether it is the Rand study that showed it could put 300,000 to 400,000 people out of work in this country or whether it is the NFIB CONSTAD study that showed nearly 800,000 people could be put out work by this kind of mandate, the very simple and often rhetorical comment back from the other side is, "Oh, well, but this program is going to hire a lot more people."

What about those who are put out of work? They are not saying they will be put back to work, because it is a different kind of work. It is a different kind of employment under a different kind of knowledge or understanding or training base than that which those people who were mandated out of work by this kind of legislation found themselves working at when they were put on the unemployment rolls. That is an issue we are all going to have to deal with in the coming days of this debate.

But I think what is fundamentally important here are some of the remarks that I want to pass on that are well beyond the general range of philosophy or attitude about whether we do or do not want a particular kind of health care reform. Because what I think is most significant is that every Senator that I visited with, that I have worked with here in the last several years as this issue of health care reform has emerged amongst the American people, has said they want health care reform. We not only want it, we not only desire it, we think it is important for our country to resolve the problems of the current health care delivery system, as numerous as they are.

But the question is, what kind of reform? That is why this debate becomes so important. That is why it is darned important that we have canceled the August recess because this is the time that the majority leader, Mr. MITCHELL, decided we are going to debate health care.

Then let us be here debating it. Let us put all of these bills out on the table, spread them out for the American people to understand, spread them out for them to leaf through and to read the fine print and to be able to make the individual determination as to whether this is going to affect them in the right way or the wrong way, whether it is going to give them the options that they need.

Mr. President, before I go any further, I would like to add that I am extremely frustrated, though, by this process, and I am frustrated because I am not quite sure where we are at this moment.

When I say that, I am not sure which version we are talking about, because when the debate began, we had Clinton-Mitchell 1, some 1,404 pages that we were to study, to understand and to spread upon the table, as I have just mentioned. But that is not the case at this moment. At this moment, we are on Clinton-Mitchell 3 or, as Senator PACKWOOD would say, Lethal Weapon 3. But we are on the third version in less than 1 week's period of time. I do not blame the American people for scratching their heads and saying, "What are you doing?" But more importantly, "Why are you doing it that way? Why aren't we being given the ample opportunity to see, to understand and to compare the differences of all of these programs and then to be able to call you or write you, Senator CRAIG, and say, 'we prefer this over this or this particular bill will affect us in this way, as this bill would cause us some problems.'"

That is the frustration we are dealing with, and my constituents have been clamoring to see the bills since they were originally introduced. The moment the Mitchell bill became available, we started getting phone calls. So we sent copies of those bills out to our district offices across the State. But as I just mentioned, the mail takes 3 days from the time you send it from the office here in the Senate to an Idaho office. And in that 3 days, that 1,400 page document that was in transit in the mail was obsolete because Leader MITCHELL had come to the floor with another bill.

As a result, we said to our district offices, "Cancel that bill; it is out of date, wait for the other bill. As citizens come in, they can take a look at it. Tell them the chapters, sections, and subsections will be different, because the new bill, version 2, is on its way."

Mr. President, before version 2 got to our district offices in Idaho, version 3 was on its way.

I am told that the first printing of this particular piece of legislation cost the American taxpayers about half a million dollars, give or take. If it is true that the first version cost a half a million dollars, I think it is reasonable to assume, when you look at the sizes of them, that the second version of Clinton-Mitchell, and possibly the third version of Clinton-Mitchell, cost about the same amount to print and to disseminate a given number.

So we are already well over a million dollars in costs just to print a concept or an idea, long before it gets debated, long before it gets amended, long before it arrives at the refinement process that then might be acceptable to you or to me or to anyone else serving in the U.S. Senate.

Why is this going on? I am not a veteran legislator compared to you, Mr. President, but I do know one thing: That normally this kind of activity happens in committees. When we get a bill to the floor, it is usually the final version, it usually has been worked over by all of the people of authority in a given committee or a committee of authority, or maybe two committees, and then it is merged into a final product that has had months and months of work before it ever comes to the floor for a final vote. We have not only saved the taxpayers a phenomenal amount of money, we have done the workings, the craftings of the legislative process in the right way.

I cannot say that that has happened here. I am not proud of this process,

and I do not think the American people are proud of it and, frankly, I do not think they are very happy with it. But that is another matter. We are going to debate it and we are going to try to resolve the differences and, in the end, we will decide whether the product that is in process today is worthy of our support, worthy of the support of the American people or, in fact, it ought to be defeated and then we ought to go home and talk again with our constituency and come back and try to resolve it another day.

There is a bottom line, and that bottom line is that the American people believe, as I do, that the current health care system of our country deserves to be reformed; that it should not be a moving target; that it ought to be a very real, stationary, subject that we all know the pros and cons about, that we were given ample opportunity to see and work out, and then we decide in the appropriate legislative fashion that this Senate has become known for and respected for over the last 200-plus years.

For the next few minutes then, let me talk about the debate that has gone on in Idaho, in my home State, for the last several years, and what I have done as a participant in that debate and as a Federal legislator for the citizens of the State of Idaho.

Starting back in 1989 and working forward to today, I have been the sponsor of a variety of health care conferences. They have really ended up being quite large conferences, 300, 400, 500 people attending from all over the State. We have been able to draw in such speakers as former Secretary of Health and Human Services Lewis Sullivan; former Administrator of the Health Care Financing Administration, better known as HCFA, Gail Wilensky; from the Heritage Foundation, Stuart Butler; from the University of North Carolina, Kenneth Thorpe; and from Harvard School of Public Health, Dr. William Hsiao—all of these people, noted authorities of their time, of their day in health care. They have come to our State at my encouragement to explain, to debate and to answer questions for the citizens of the State of Idaho.

I have also held town meetings and health care conferences—in a smaller fashion—on reform across the State. I guess in the last year I have probably held six or seven of these kinds of conferences, providing for the citizens of Idaho just as much information as was available at the time.

And there has been one theme line that I have encouraged in Idaho—not that I showed a bias, or not that I suggested one program over another. I told them the programs that I was a cosponsor of, but I said, "It is time, Idaho, that you get involved in this debate, that you get to know as much as you can about President Clinton's plan or about the Heritage plan or about any other plan that is out there," because at that time, and very similar to what I said just a few moments ago, I used a very simple line, and that was, Mr. President, to the citizens of Idaho, I said: "This is the most significant piece of public policy that you will be involved in, in your lifetime. You deserve to know about it and, more importantly, I deserve to know what you think about it before I cast my final vote."

As a result of that, from the conferences to the town meetings to the publications, to all of these Mitchell plans that I have been sticking in the mail and shoving out to our district offices and letting the people know that they were there and they could come in and read them, sort through them, question them, call me back, Idahoans became engaged in this debate more than any other I have ever been involved in, in the 14 years I have represented them.

Thousands of cards and letters have come back, telegrams, faxes. We are receiving hundreds of letters a week now from them on the health care issue. That is what I hoped Idahoans would do. Their resounding message that comes back in almost all instances would be and is, Idahoans are saying to their Senator: We would prefer no bill to a bad bill.

So the question is, Mr. President, what, by the definition of the Idaho understanding, is a bad bill? In my opinion, in reading all of those letters, Idahoans define a bad bill as that which requires more Government involvement in the health care delivery system of their State. They want reform, because all of those letters that talk about getting a piece of legislation talk about reform.

But I am telling you, they understand very clearly the kind of reform they want. They recognize what needs to be done. But Idahoans also recognize a lot of other things, as I think most of our citizens do. Idahoans realize the importance of the fact that 84 percent of all Idahoans are now currently insured, are now currently covered under a variety of health care insurance programs. In anyone's book, that is an overwhelming majority.

Does that mean there are no problems? No, I have already said, Idahoans want reform because they recognize that there are problems, significant problems. But they also recognize that when you look at the figures of 84 percent insured, that means there are 16 percent that are uninsured. And guess what? As logical and conservative as Idahoans are, they say, "Why don't you work to solve the problems of the 16 percent instead of creating a whole new, large, Federal bureaucracy to deal with the whole system when 84 percent of Idahoans, like many other Americans, are already covered?"

That is the issue at hand.

So I think Idahoans have defined what they think is the problem. People are worried that they will lose their health care if they have a serious illness, because their insurance might be canceled. They think that is a problem in Idaho, and they want us to solve that problem, or try to work with them in solving it.

They worry that they would be kept from getting insurance if they were to change their jobs. I think we call that portability around here. And Idahoans say, "LARRY, fix that." They are concerned about whether they will be able to afford insurance by reason of the rate of increase in cost. And they say, "Can't you resolve some of the cost factors that are driving that?"

They have a strong desire to be able to purchase the services they want from a doctor or a health care provider they choose. In other words, Idahoans want choice of the kind they have felt they have always had. They do not want a Federal agency or a regional agency or some kind of federally created co-op saying no, here are the doctors that are going to provide you with this kind of care. We are not going to give you that kind of flexibility or choice. That is a concern that I think most Idahoans have.

And another thing I think they feel is most important is they do not want what they have changed. In other words, they say, "Take care of the 16 percent, adjust us around a little bit, deal with some of these problems, if you can, but do not change the system to an all-federalized system."

In other words, they are saying we do not have to sacrifice the quality that we are getting or pay billions more in new taxes to make that system accessible for those who are currently locked out.

Let me make it very clear, Mr. President, I am not saying we do not need reform. Idahoans are not saying we do not need reform. It is quite the opposite. We need reform, the kind that will solve the problems in the system. What we need is not a new Government program that costs us billions of dollars to resolve this problem. There are pieces of legislation, there are bills before us that approach it just exactly the way I think a majority of Idahoans would want us to deal with it.

Idahoans are not unique in their rejection of the Clinton bill or other Clinton-like proposals. Their concerns arise from the fact that most Government one-size-fits-all programs really do not fit Idaho.

Idaho and other frontier States have unique needs in health care delivery. For example, Idaho has one of the worst doctor-to-patient ratios in the Nation. Therefore, access to care is not merely a question of the ability to pay. Under the bill that we now know as Dole-Packwood, there are a number of

very important provisions listed under title III, "Special Assistance to Rural, Frontier and Unserved Urban Areas."

There is a special word in the title, Mr. President. I have now used it twice. And that is the word "frontier." That word does not appear in the Clinton-Mitchell bill. According to my research and a run of the computer and a check in the way we can check things today, the word does not appear. It is alarming to me that the Clinton-Mitchell bill does not recognize, nor does it understand, what I call the rural West.

Frontier and rural are two very different situations because they, say, "Well, Senator, if you are talking about rural, then we are dealing with the question of frontier." But I will tell you that it means two distinctly different kinds of communities that we clearly have in our State of Idaho and that many other Western States have. Residents may have the benefit of a clinic but often they have to travel many miles to a larger community to be treated for a complex health problem.

It is important to note that in Idaho that drive is not 20 miles down a stretch of interstate. Rather, it is on a winding mountain road that is closed part of the year because of snow or ice. While that depiction may seem melodramatic, it is also very accurate and relates to the definition of frontier. And I suspect in the President's State of West Virginia that definition also applies, because oftentimes it is not 20 miles down the interstate but 200 miles to the nearest doctor or the clinic or to any environment in which health care can be delivered.

The question of access in Idaho is more than we can afford these medical services. It is can we get to a doctor or a hospital when we need help. Idaho and other frontier States face this and other very unique problems. The Dole-Packwood bill does more than reference our needs.

Now, remember, I have just said a computer check of the language suggests that those words do not even appear in the Clinton-Mitchell proposal. The Dole-Packwood bill speaks to rural or frontier provisions in title III, as I have mentioned.

For example, there are funding provisions to help providers and health plans establish networks in underserved areas. Subtitle A provides for demonstration grants, subtitle B provides for technical assistance grants, and subtitle C includes capital assistance loans and loan guarantees.

The Packwood-Dole bill also establishes safeguards to enhance access to local health care services and practitioners for vulnerable populations.

Under subtitle D, there is funding to increase the number of primary care providers in medically underserved areas which is critical to my State of Idaho and many of the, by definition, rural and frontier States of the West and other parts of the country where we have the worst doctor-patient ratio than any other place in the Nation.

Another important provision under this rural frontier title is subtitle F, which is on the emergency medical system side. This subtitle includes grants to States for aircraft in transporting victims in medical emergencies, and that is section 361. In Idaho, Life Flight and other similar services have saved many lives, and I think the President knows what I am talking about. A person injured in the back country can be brought out instantly, or nearly instantly, as fast as the helicopter can fly from the point where the person was injured to a major medical complex sometimes 200 and 300 miles away.

The Dole-Packwood bill addresses this issue very clearly. Again, it goes unaddressed in the Clinton-Mitchell proposal.

Now, I have also mentioned Idaho has a varied terrain and climate with many remote frontier communities that are unreachable during certain times of the year except by aircraft, and section 361 is critical in any kind of health care reform we do to make sure that all of America is served, not just the urban areas but certainly the rural and, by definition, the frontier areas of our country. Again, the continual reference to and focus on frontier health issues in the Dole-Packwood bill are two of the many reasons why I have been able to support it and why most Idahoans, after they have been given the opportunity to read it and understand it, begin to support it also.

As we work out a health care reform bill, we must address the unique needs of frontier States and acknowledge that a one-size-fits-all plan simply will not work in Idaho, and other rural or frontier States.

In light of some of these frontier access problems that I have mentioned, I would like to talk a little bit about how Idahoans are already working to solve problems in our State. I will be brief about these topics, but I think they are important to understand, because Idaho is not unique. Like many other States, they are working to solve their own problems. Proposals under consideration, and already passed by the Idaho Legislature, clearly begin to drive the issue of health care delivery in our State and make it more accessible to more people.

Specific strategies are being employed by the Idaho Legislature. Communities like Twin Falls, ID, are developing unique plans, and in the five northern Idaho counties, health care facilities, along with health care providers, are coming together in a very innovative community health care network.

So, Mr. President, my purpose in sharing these ideas and activities going on in Idaho is to encourage my colleagues to take a close look at what is happening in their own States.

In this Congress, we have the unique opportunity of developing an infrastructure that will empower people. Empowerment should be our focus, not restrictions and prohibitions.

Let me restate that. When we look at what our States are doing, Mr. President—and many of our States are being very innovative at this moment in health care delivery—what we do here ought to be played in the backdrop, or at least alongside, of what our States are doing. We ought to assure that what we do empowers our States and does not restrict them or prohibit them, and saying again that we know better and that one size fits all. Because of our very specific needs—and I have addressed some of them—the reforms in Idaho have been focused on increasing accessibility while containing costs.

Over the past few years, the Idaho Legislature has passed laws to improve health care accessibility and coverage by reforming the insurance industry. You and I both know that the insurance industry of our country is primarily regulated at the State level. We have not ever created a great national, federalized bureaucracy that controls that industry. We have said that is primarily a State responsibility. And, as a result, almost every State to my knowledge has an insurance commission. An insurance company, to do business in that State, has to conform with the rules and the regulations of the State.

Our Idaho Legislature, understanding that of course, then has worked inside the State to reform the insurance industry to develop a variety of things, but beyond that, to make sure that there is greater accessibility.

The Idaho Legislature has also allowed the development of medical savings accounts. Of course, that means you can put away pretax dollars, State tax dollars, to be used for the purposes of purchasing health care. Guaranteeing health care access to individuals in small communities has been improved by these kinds of approaches.

Other proposals under consideration include the development of incentives to further reduce health care costs and improve that doctor-to-patient ratio that I mentioned that in Idaho is the worst of any rural State in the Nation. Insurance reforms that passed the Idaho Legislature this immediate past session include the transferability of policies so that people will not lose insurance coverage simply because they change jobs. In other words, the Idaho Legislature has done what we are debating about doing. It is called portability. But let us make sure that our portability, if we can get that far, does not wipe out the kind of portability that the Idaho Legislature has provided for the citizens who live within

that State and buy health care coverage there.

There is also an individual insurance plan called the Individual Health Insurance Availability Act, which guarantees access to health insurance for individuals. That legislation was passed a couple of years ago in Idaho. For the last year and a half, I have met with a variety of insurance companies that have worked together to build a basic policy that allowed people of lesser means to buy minimum health care coverage to gain access to that system. That policy is now available in the State of Idaho. It costs less but provides the kind of minimum coverage that many of our citizens are looking for. That is what health care reform is all about. The Idaho Legislature is doing that right now.

We should not, by our actions here, risk canceling out any of those kinds of activities. These provisions are similar to provisions included in many of the health care reform proposals that I have mentioned here. They are also real solutions to problems that cut people out of the current system.

That is what I think our reform should be dealing with, Mr. President. I am not saying that the Clinton-Mitchell bill does not deal with some of those because they attempt to in their own way. But they set up this vast bureaucracy around it that is going to create the Federal regulator determining what is good or bad for Idaho, instead of an Idaho Legislature or an insurance company working with an Idaho insurance commission to assure the portability or to ensure the minimum insurance policy that Idahoans can afford.

Reducing paperwork and establishing medical savings accounts are both proposals that I support and are included in legislation that I have cosponsored here in the U.S. Senate. The Idaho Legislature has already addressed those very items. But under a Clinton-Mitchell type bill, all those positive actions in most instances would be wiped out and in other circumstances could be wiped out.

In addition, new burdens would be placed on States both financially and administratively. Why should we do anything that would wipe out any action that any of our States would be taking to drive down these costs, to reduce the paperwork, and create the greater accessibility?

In recent reviews of the original language received on the Clinton-Mitchell bill, there were 175 new responsibilities that would be imposed on our States. I would suggest that probably the State of Idaho is not going to be able to afford to administer the kind of very simple, clean, and adequate proposals that it has brought about if it has to address the 175 new responsibilities that are involved in the Clinton-Mitchell approach.

The Idaho Legislature has taken major steps toward solving the State's health care problems. As I have already mentioned, Federal reform should enhance, rather than inhibit, what we are doing here. In other words, what I said before, let us empower people, let us empower our States, and let us empower the systems of government that are closest to the people to reform their health care instead of prohibit them from doing so or restricting them or burdening them down with bureaucracies through this legislation.

In the private sector, a number of voluntary actions have been taken to improve access to care in Idaho. Over the past 6 months, as I mentioned earlier, a group of community leaders in the Twin Falls area have adopted the vision to make their region the healthiest place in America. That is the program they are talking about. They are calling it the "Healthiest Place in America." County facilities are beginning to work together under the joint exercise of powers agreement, and physicians are beginning to form larger group practices to work with hospitals under physicians and hospital organizations. Why? To allow greater coverage, to drive down costs, to make access simpler. That is going on as we speak.

In Twin Falls, ID—and in the "Twin Falls" across this Nation—whether it is in your State of West Virginia or any other State, communities and providers are coming together saying they can solve a lot of these problems on our own, and they are doing it. The tragedy is: Is what we are doing here going to thwart that or wipe it out? More than likely, it could. However, for the Twin Falls community to develop its network, it cannot be obscured by Federal legislation.

Mr. President, I hope that the Senate will take into consideration the reform efforts already passed by State legislatures across this country.

In my opinion, after having read at least half of the Clinton-Mitchell bill now and having read all of the Dole-Packwood bill, I would say that the Dole-Packwood bill comes much, much closer to working as a cooperating partner with States and local providers than the large, Federal dictating bureaucracy that inevitably will be constructed coming out of final passage of a Clinton-Mitchell approach. The Congress needs to focus on establishing a framework in which the market can develop a process that naturally fits the States and that the States are working toward today.

I mentioned also the communities in the north end of my State. One-hundred-sixty physicians and north Idaho hospitals have come together to create what they have called the North Idaho Physicians' Association. They will serve as a discussion and an educational group. They are working together with a coalition of hospitals in the area. This association has performed a local study of the needs of the beneficiaries, the employers, and the providers. It is very likely that there is no other group that understands the health care needs of northern Idaho better than that association I have just mentioned and the residents of the communities they serve—certainly not the bureaucrats here in Washington, or certainly not a regional office or offices that would be established in Seattle, or Portland, or Salt Lake City, or some other place, that would dictate and begin to control under any of the plans being proposed that we call greater bureaucratic plans, much like the Clinton-Mitchell approach.

The north Idaho organization is dedicated to providing accessible, high-quality health care while containing costs in their communities. This confirms my belief that health care is most efficient when it is coordinated both locally and privately. And, again, I hope that this Senate in its debate and in the amendment process and in the final resolution of health care will clearly recognize that in communities and States around this Nation today, health care is being revolutionized not by a Federal edict, not by overpowering Federal legislation, but by the simple needs of the marketplace and the recognition that you can get quality health care if you deliver it privately, or if you cooperate with State and local units of government instead of a large Federal bureaucracy.

Propelled by a sense of community and desire to improve health care in their own area, I have just mentioned three major efforts going on in Idaho, whether it was the legislative effort, the community effort in north Idaho, or whether it is Twin Falls wanting to make themselves the healthiest place in the country.

Mr. President, these are examples of what we can do and, more importantly, what we are doing in our health care delivery system in this country. The pressure is on, or we would not be debating health care reform here today. But let us make sure that pressure does not drive us over the edge toward a greater Federal bureaucracy but, in fact, it causes us to work hand in hand.

Before going on to discuss legislation here in the Senate that I support, I would like to add that thousands of letters and phone calls have been pouring into my office stating opposition or concern about the Clinton-Mitchell bill.

I ask unanimous consent that two letters in opposition to the National AARP endorsement of the Clinton-Mitchell bill be printed in the RECORD.

There being no objection, the letters were ordered to be printed in the RECORD, as follows:

JAMES O. MCMAINS,
CERTIFIED PUBLIC ACCOUNTANT,
Lewiston, ID, August 11, 1994.

EUGENE LEHRMAN,
AARP, Washington, DC.

DEAR MR. LEHRMAN: I watched as you endorsed the Democratic Health Care bills on National TV yesterday on behalf of the members of AARP.

How dare you presume to speak for me without asking my opinion first!

I know there are many, many members who feel as I do; that the principal reason for the rise in health care costs over the past three decades has been the Government programs that are already in existence (including Medicare, Medicaid, Welfare, etc.).

The federal Government has no business mucking about in health care. This is solely a concern of the various states and individual citizens.

I thought AARP, because of the age and experience of it's members would have better sense. Apparently the leadership of the organization has concluded that money grows on trees and that the Government can give people something without taking it from someone else (your children and grandchildren).

Since the AARP does not represent my views, and since I was not even asked my views before the announcement of support for the Government takeover of the health care system, I hereby cancel my membership. My membership card is enclosed.

Sincerely,

JAMES O. MCMAINS.

BOISE, ID,
August 10, 1994.

ANNE MAY KINSEY,
President,
American Association of Retired Persons, Washington, DC.

DEAR MS. KINSEY: It may come as a surprise to the individuals at A.A.R.P. who took it upon themselves to announce their support, and by inference, my support of the Clinton/Mitchell health plan today, but I did not give them my proxy to do my thinking for me or to represent my beliefs to others.

Like millions of others, I have followed the health care debates for some months, and when the smoke and mirrors are eliminated, one must conclude, at least based on the information available to us to date, that the opposition's charges of political expediency, massive boon-doggling and a liberal dose of socialism are correct.

I can not believe that anyone at the A.A.R.P. has made a careful study of the two major bills presented by the administration, much less have an intelligent and objective opinion at this stage as to the merits and/or demerits of same.

You may be sure that the arrogance of the A.A.R.P. "leadership" in supporting the Clinton/Mitchell plans is resented by a large share of its membership. This is merely one more example of an unwarranted belief by may residents of the Washington, DC "beltway" that they possess superior intellect and judgemental capability, whereas just the opposite would appear to be the case.

Now that the A.A.R.P. has taken it upon its self to falsely represent my views, I have a right to insist that, following your "careful evaluation" of the Clinton/Mitchell plans, you tell me:

(1) How much will the Clinton/Mitchell plans cost me, including EVERY SINGLE HIDDEN COST, and

(2) What benefits will I receive as compared to what I am able to obtain from existing private health plans, including the A.A.R.P./Prudential Plan.

I look forward to a detailed early reply, complete with your SPECIFIC evaluations which caused you to arrive at your publicly announced decision to support the Clinton/Mitchell plans.

Sincerely,

VERNON B. CLINTON.

Mr. CRAIG. For the last several days, there have been a great deal said on the other side of the aisle about this AARP endorsement. I noticed that in the last few hours those comments have gone silent. Let me refer to these letters, to give you an example of why no longer do we talk so openly or do the Clinton-Mitchell supporters talk so openly about this kind of an endorsement.

Here is a letter from James McMains, in Lewiston, ID, to Eugene Lehrman, AARP, 1909 K Street, Washington, DC.

DEAR MR. LEHRMAN: I watched as you endorsed the Democratic health care bills on national TV yesterday on behalf of the members of AARP.

How dare you presume to speak for me without asking my opinion first!

The reason a member of AARP can say that is because, historically, that organization has been very good at polling its members before it took positions on a major piece of legislation.

Mr. McMains goes on to say:

I know there are many, many members who feel as I do; that the principal reason for the rise in health care costs over the past three decades has been Government programs that are already in existence (including Medicare, Medicaid, Welfare, etc.).

The Federal Government has no business mucking about in health care. This is solely a concern of the various States and individual citizens.

I thought AARP, because of the age and experience of its members, would have better sense. Apparently, the leadership of the organization has concluded that money grows on trees and that Government can give people something without taking it from someone else (your children and grandchildren).

Since the AARP does not represent my views, and since I was not even asked my views before the announcement of the support for the Government takeover of the health care system, I hereby cancel my membership. My membership card is enclosed.

Sincerely, James O. McMains of Lewiston, Idaho.

Here is a letter to Anna May Kinsey, President, American Association of Retired Persons. This letter is from Vernon B. Clinton of Boise, ID.

DEAR MS. KINSEY: It may come as a surprise to the individuals at AARP who took it upon themselves to announce their support, and by inference, my support, of the Clinton-Mitchell health plan today, but I did not give them my proxy to do my thinking for me or to represent my beliefs to others.

Like millions of others, I have followed the health care debates for some months, and when the smoke and mirrors are eliminated, one must conclude, at least based on the information available to us to date, that the opposition's charges of political expedience, massive boondoggling and a liberal dose of socialism are correct.

I cannot believe that anyone at the AARP has made a careful study of the two major bills represented by the administration, much less have an intelligent and objective opinion at this stage as to the merits and/or the demerits of same.

You may be sure that the arrogance of the AARP "leadership" in supporting the Clinton-Mitchell plans is resented by a large share of its membership. This is merely one more example of an unwarranted belief by many residents of the Washington, D.C. "beltway" that they possess superior intellect and judgmental capability, whereas just the opposite would appear to be the case.

Now that the AARP has taken it upon themselves to falsely represent my views, I have a right to insist that, following your careful evaluation of the Clinton-Mitchell plan, you tell me: (1) How much will the Clinton-Mitchell plans cost me, including every single hidden cost and, (2) What benefits will I receive as compared to what I am able to obtain from existing private health plans, including the AARP/Prudential Plan.

I look forward to a detailed early reply, complete with your specific evaluations which caused you to arrive at your publicly announced decision to support the Clinton-Mitchell plans.

That is signed Vernon B. Clinton from Boise, Idaho.

Well, at least this gentleman did not resign his membership card. But he does call upon that organization to examine thoroughly the very bills we are talking about.

Mr. President, you know, it is the same kind of call that many of us have made and why we are now here on the floor asking the questions and debating this issue. I know that, earlier on, Senator KENNEDY asked, "Why are we not debating the Dodd amendment?" I do not argue that that is not an important amendment. It is a critical amendment, as is any kind of legislation that we do.

Mr. KENNEDY. Mr. President, will the Senator yield just on that point?

Mr. CRAIG. I am happy to yield.

Mr. KENNEDY. Mr. President, I was listening with great interest to the Senator talk about the different initiatives that were taking place in the State of Idaho. I found those enormously interesting.

I was just reviewing the census figures on the number of uninsured children, because this is something which the Dodd amendment was addressing, and I thought at least I gathered from the Senator from Idaho he is indicating that Idaho was really just reacting, dealing with their own kinds of problems, and, therefore, we did not need or at least have the kind of comprehensive approach that might be included in the Mitchell proposal or perhaps even in the Dole proposal.

According to last census, which is March 1992, there are 13 States in the United States that have a higher percentage of uninsured children than Idaho.

The PRESIDENT pro tempore. The Chair will observe that the Republicans' time has expired.

Mr. KENNEDY. Mr. President, will the Senator yield 4 or 5 minutes?

Mr. MOYNIHAN. Of course, Mr. President. I am happy to yield 5 minutes to the distinguished Senator from Idaho.

Mr. CRAIG. Mr. President, let me respond to the Senator from Massachusetts. He does bring up a very valuable point. That is why I said at least twice or three times during my discussion this afternoon that the Dodd proposal is a worthy proposal and ought to be debated.

This is why the Idaho legislature 2 years ago said by law to their insurance providers in the State you have to do better, and that is why those providers came together and are just introducing a new plan that is now on the ground in Idaho that is a comprehensive minimum plan that would allow hopefully increased coverage for many of those children the Senator talks about.

Idahoans are very aware and very concerned about that problem. That is why Idahoans say we want health care reform.

I have said that, Mr. President, today time and time again on the floor. We want health care reform. We want Idahoans to have that choice. We want to make sure that our children are covered.

The tragedy is Idahoans cannot pay for the 20 percent tax increase that the Clinton-Mitchell proposal would require of most Idahoans to be able to afford that kind of insurance.

We in Idaho believe that under the proposal of the Idaho legislature that is created and the portability issue that they are now addressing and the medical savings account issue that they are now addressing we can handle the issue of uninsured children in our State more adequately than can be provided under a larger Federal bureaucratic umbrella.

I thank the Senator for questioning. He is absolutely correct. It is of major concern in my State. We want to be responsive to it. But I think Idahoans under the choice of their plans would prefer to be responsive under a Dole-Packwood plan and a plan that would not cancel out the initiatives that are currently underway in our State.

Mr. KENNEDY. I thank the Senator for his comments.

There are several States that effectively have included what the Dodd amendment would achieve and accomplish. I was not aware that Idaho was one of those. But I appreciate the fact. In the Dole proposal, to which the Senator referred, according to the Lewin VHI assessment, there will be 6 million children that will be uninsured at the end of the decade.

I also heard the Senator talk about the value that Idahoans place on the freedom of choice proposal. I have examined the Dole legislation, all 600 pages of it, and I cannot find where the guarantee of choice is evident in that legislation. I do not know.

If the Senator wanted to review it and answer another time, I will be glad to defer. I do think, that one of the key elements of any reform is what is going to happen to children. The Dodd proposal does provide the requirement that States make available to children preventive health care services which quite frankly, according to other GAO studies, show just about every other industrialized society in the world provides except the United States.

Would the Senator reason with me about how we are going to try and deal with the needs of the 6 million children that will be left uninsured by the Dole proposal. Maybe there will not be as many uninsured children in the State of Idaho as might be even now. But if we are looking at how we are going to insure the total coverage of children, how would he expect that the Dole proposal would do it, and if he could help me locate within the Dole proposal where freedom of choice is guaranteed.

Choice is a major factor that is included in the Mitchell proposal, but as we move on through now in the third day of at least the debate on the children's proposal we would like to find out how you are going to address the studies that show there will still be 6 million that will not be covered, and there are no guarantees of freedom of choice under the Dole proposal. If the Senator could just respond to that.

The PRESIDENT pro tempore. The time has expired.

Mr. MOYNIHAN. Mr. President, I am happy to yield to my friend from Idaho such time as he requires to answer the Senator from Massachusetts and to finish his opening statement.

Mr. CRAIG. I thank my colleague for yielding.

The PRESIDENT pro tempore. The Senator from Idaho is recognized for such time as he may consume for such purposes.

Mr. CRAIG. Mr. President, the Senator from Massachusetts makes an excellent point, and I must restate again that the citizens of Idaho are very aware and very concerned about uninsured, uncovered, and underserved children. It would be wrong to suggest in any regard that the children are not being served. We all know that they are being served.

The question is, is it of the ongoing quality accessible in reasonable fashion that, first of all, creates a healthy environment for that child? By that I mean from the time of that child's birth forward, and of course through the mother's pregnancy, are those services being provided and do they get their necessary immunization, and all of that?

That is what concerns Idaho most. While I recognize that it is hard for the Senator from Massachusetts to realize that the Dole bill does not speak to choice, it is choice. It does not have to speak to choice because it does not control the marketplace. It only enhances the marketplace. So choice by itself is the bill.

The difference between the Dole and Mitchell bill is that in the Mitchell bill you create a restricted Federal bureaucracy that says you do thus and so and that guarantees certain kinds of things. The Dole bill says, and I refer to the section which talks about insurance reform and the standard applicable health care plans and the right of renewal, and all of that, and that was the very thing that Idahoans attempted to address was that when you make those kinds of programs available by driving costs down you bring uninsured families into the market. You bring them into coverage.

There is another issue that has to be spoken to here when you talk about uninsured children. Dad may be insured because he works under an environment in which he is covered, or mom may be insured, but the family may not be insured. That does not say that the children are not going to be cared for or that they are not being covered. By the very nature that their family can afford health care coverage, they are being covered.

So we know that those statistics, depending on how you break them out, always vary a little bit. But what I think we are talking about here are two fundamentally different proposals. I have not analyzed the Dodd amendment. I do not know how it fits inside the Clinton-Mitchell proposal or whether something similar could fit inside the Dole-Packwood proposal. I do recognize when you drive down costs and when you create the kind of reforms that are out there is a substantial chance that you are going to create greater coverage for children who are uninsured or you are going to create a much more affordable environment so that the parents of those children can provide for their children as, of course, most of them want to do.

Let me make a few closing comments because the chairman has been generous in his time with me in so doing.

Mr. President, this debate is one of the most significant debates our Nation has ever held. Now, the Congress will work to approve a bill.

It is my hope that we can work to represent the will of the American people and will end up with legislation that will change what is not working in the health care system, while retaining what is good in it.

There are numerous issues that will be debated over the next few days or weeks—as long as it takes to work through these issues. We should be here debating and developing a better understanding of what we do.

Mr. President, I have been dismayed by the remarks made regarding those of us who wish to clearly express our opinions on this issue and the bills before us prior to entering debate on amendments.

This bill is lengthy and has changed no less than three times as of today. The points of debate on the bill will likely range from major philosophical differences to more technical details.

As we work through this process we need to remember that what is done here will dramatically affect the lives of each and every American and deserve careful consideration. Therefore, our efforts should reflect what our constituents have been telling us. In the final days of the 103rd Congress—health care reform should not be used as a political tool to save a President. Health care—quality-accessible health care and its reform is more important than a President and his political life.

Mr. President, I would now like to talk a little about what the people of Idaho have been telling me about health care reform, and the position I have taken as a result of those comments and my study of this issue. It is also important that I explain the concerns I have about the Clinton-Mitchell bill.

Mr. President, before I go any further, I would like to add that I am also extremely frustrated that not only have we had very little time to review the very lengthy Clinton-Mitchell bill, but it remains a moving target.

We now have version three—Senator PACKWOOD would say lethal weapon III—of the Clinton-Mitchell before us. Numerous changes were made in version two and as I have begun to review version three, it appears that changes again have not been minor.

My constituents have been clamoring to see the bill since the original introduction. Copies of Clinton-Mitchell one were immediately mailed to my State offices so that Idahoans could come in and review areas of interest. Before those bills even reached my State, they were outdated.

In addition to being outdated, it came to my attention that the cost of that first printing was in the range of half a million dollars.

Again, Mr. President, we are on Clinton-Mitchell three—this bill is costing American taxpayers too much before it has even passed the Congress. We all knew these bills were costly—what we did not know is that millions would be spent before they ever became law.

IDAHO

Mr. President, in Idaho we have all been working to educate ourselves on this moving target called health care reform.

I felt that it was important to get information out to the State, and to help pursue this debate in Idaho.

Toward that end starting in 1989 I have sponsored health care conferences that have drawn such speakers as: former Secretary of Health and Human Services Louis Sullivan, former Administrator of the Health Care Financing Administration Gail Wilensky, Ph.D., from the Heritage Foundation Stuart Butler, Ph.D., from the University of North Carolina, Kenneth Thorpe, Ph.D., and from Harvard School of Public Health Professor William Hsiao.

I have also held town meetings on health care reform all over the State and spoken to a variety of civic and private groups on this issue, in addition to receiving thousands of letters.

A resounding message that has been coming from Idahoans is that:

They would prefer no bill to a bad bill. And Idaho defines a bad bill that requires more Government involvement in health care.

Reforms should focus on what is wrong with the system and leave what is good alone.

Idahoans realize the importance of the fact that 84 percent of Idahoans have health insurance.

In anyone's book that is an overwhelming majority.

Does that mean that there is no problem?

Not at all, but it does mean that some things in the system are working.

In reform, we need to focus on what is not working and resolve those problems—the problems that are keeping 16 percent of Idahoans and other Americans uninsured.

Many Idahoans have written in explaining problems they have experienced. Some of the biggest problems Idahoans have identified are things like:

People worrying they will lose their health insurance if they get a serious illness.

Worries we can not keep an insurance plan we like, or need, if we lose a job or decide to change jobs.

Concerns about whether we'll be able to afford insurance because the costs of health care go up too fast.

A strong desire to be able to purchase the services they want from the doctor or health care provider they choose.

Those are important concerns and important problems and they're what I want the Congress to address.

Mr. President, as we address these concerns, we must not lose what is good in the system—what takes care of most Americans—in order to get coverage for those without insurance.

We do not have to sacrifice quality or pay billions more in new taxes to make the system accessible for those who are currently locked out. Let me be clear Mr. President, I am not saying we don't need reform. Quite the opposite. We need reform, the kind that will solve the problems in the system.

What we do not need, Mr. President, is a new Government program that costs us billions in new taxes and doesn't meet our needs.

Idahoans are not unique in their rejection of the Clinton bill or other Clinton-like proposals. Their concerns arise from the fact that most Government one-size-fits-all programs don't usually fit Idaho.

Idaho and other frontier States have unique needs in health care delivery. For example, Idaho has one of the worst doctor-to-patient ratios in the Nation; therefore, access to care is not merely a question of the ability to pay.

Under the Dole-Packwood bill there are a number of very important provisions listed under title III: special assistance for rural, frontier and underserved urban areas.

There is a very special word in the title, Mr. President, and that is "frontier." That word does not appear in the Mitchell-Clinton bill, according to my research. This should be an alarming point for the rural west.

Frontier and rural are two very different situations. Idaho is a State of both rural and frontier communities. Some communities in Idaho do not have a physician.

Residents may have the benefit of a clinic, but often have to travel many miles to a larger neighboring community for treatment of more complex health problems.

Mr. President, it is important to note that in Idaho that drive is not 20 miles down a stretch of interstate. Rather, it is often a winding mountain road that is closed part of the year because of snow and ice. While that depiction may seem melodramatic, it is also very accurate and relates to this definition of "frontier." 200 miles to a doctor or a clinic is just not an unusual situation.

The question of access in Idaho is more than "can we afford these medical services?" It is, "can we get to a doctor or a hospital when we need help?" Idaho and other frontier States face this and other unique problems.

The Dole-Packwood bill does more than reference our needs. There are a variety of rural or frontier provisions in title III of Dole-Packwood:

For example, there are funding provisions to help providers and health plans establish networks in underserved areas. Subtitle A provides for demonstration grants. Subtitle B provides for technical assistance grants. And, subtitle C includes capital assistance loans and loan guarantees.

The Packwood-Dole bill also establishes safeguards to enhance access to local health services and practitioners for vulnerable populations. Under subtitle D there is funding to increase the number of primary care providers in medically underserved areas, which is critical for Idaho—where we have the worst doctor-to-patient ratio in the Nation.

Another important provision under this rural/frontier title is subtitle F, which is on emergency medical systems. This subtitle includes grants to States for aircraft for transporting rural victims of medical emergencies (Sec. 361). In Idaho, Life Flight and other similar services have saved many lives. As I mentioned before, Idaho is a State with varied terrain and climate,

with many remote frontier communities that are unreachable during certain times of the year except by aircraft.

Again, the continual reference and focus on frontier health issues in Dole-Packwood are one of many reasons why I have supported it.

As we work out a health care reform bill, we must address the unique needs of frontier States and acknowledge that a one-size-fits-all plan simply will not work in Idaho and other rural or frontier States.

In light of some of these frontier access problems I have mentioned, I would like to talk a little about how Idahoans are already working to solve problems in our State. I will briefly address three specific topics today:

First, proposals under consideration and already passed by the Idaho State Legislature;

Second, specific strategies being employed in the Twin Falls area; and

Third, an innovative community health network developing in five northern Idaho counties.

Mr. President, my purpose in sharing these ideas and activities going on in Idaho is to encourage my colleagues to take a closer look at what is happening in their own States.

In this Congress, we have the unique opportunity of developing an infrastructure that will empower people. And, empowerment should be our focus, not restrictions and prohibitions.

Because of our specific needs, reforms in Idaho have focused on increasing accessibility while containing costs.

Over the past few years the Idaho Legislature has passed laws to improve health care accessibility and coverage by reforming the insurance industry, developing medical savings accounts, and guaranteeing health care access to individuals and small businesses.

Other proposals under consideration include developing incentives to further reduce health car costs and improve the doctor-to-patient ratio.

Insurance reforms that passed Idaho's legislature this session include the transferability of policies so that people will not lose insurance coverage simply because they change jobs. That's call portability, there is also an Individual Health Insurance Availability Act which guarantees access to health insurance for individuals. I have met with the insurance companies as they worked to offer this affordable approach. These provisions are similar to provisions included in many Federal health care reform proposals. They are real solutions to problems that cut people out of the current system.

Mr. President, in addition to these insurance reforms, Idaho has passed laws reducing the amount of paperwork required and establishing medical savings accounts.

Reducing paperwork and establishing medical savings accounts are both proposals I support and are included in legislation I have cosponsored here in the U.S. Senate.

Under a Clinton-Mitchell type bill all those positive actions would be wiped out. In addition, new burdens will be placed on the States both financially and administratively. Why should anything we do here wipe out what our States are trying to do.

A recent review of the original language revealed no less than 175 new responsibilities will be imposed on States under Mitchell-Clinton.

The Idaho State Legislature has taken major steps toward solving the State's health care problems. Mr. President, as I have already said, Federal reforms should enhance rather than inhibit what we are doing in Idaho.

In the private sector, a number of voluntary actions have been taken to improve access to care in Idaho. Over the past 6 months, a group of community leaders in the Twin Falls area has adopted the vision to make their region "The Healthiest Place in America."

County facilities are beginning to work together under the joint exercise of powers agreement, and physicians are beginning to form larger group practices to work with hospitals under physician-hospital organizations.

However, for the Twin Falls community to develop its network, it cannot be obstructed by Federal legislation.

Mr. President, I hope that the Senate will take into consideration the reform efforts already passed in the Idaho State Legislature.

The Congress needs to focus on establishing a framework in which the market can develop and progress naturally in the States.

Coinciding with the developments in the Twin Falls area, the 160 physicians of northern Idaho founded the North Idaho Physicians Association to serve as a forum for discussion and education.

Together with the coalition of hospitals in the area, this association has performed a local study of the needs of beneficiaries, employers, and providers.

It is very unlikely that any single group understands the health care needs of northern Idaho better than this association and the residents of the communities they serve—certainly not bureaucrats in Washington DC.

This northern Idaho organization is dedicated to providing accessible, high-quality health care while containing costs in their communities. This confirms my belief that health care is most efficient when coordinated locally and privately.

Propelled by a sense of community and desire to improve health care in their own area, the organization is implementing solutions to problems.

Mr. President, these examples I have mentioned clearly illustrate how the health care market can successfully respond to pressures when given the liberty to do so.

Before going on to discuss legislation in the Senate that I support, I would like to add that thousands of letters and phone calls have been pouring into my office stating opposition or concerns about the Clinton-Mitchell bill. I ask unanimous consent that two letters in opposition to the national AARP endorsement of Clinton/Mitchell be inserted into the RECORD.

They are talking about the endorsement a few days ago now they don't. Here is why.

The Congress can enhance what is already happening in Idaho, or it can put up obstacles and restrictions. It is my hope that the choice will be enhancement.

BILLS THAT PROMOTE CONSUMER CHOICE

Mr. President, the various reform bills that I have cosponsored in this Congress and in the previous Congress are designed to resolve the problems identified by Idahoans that I mentioned earlier, without throwing away what is good in the system.

I have heard some people criticizing Republicans saying we are not for reform. Or, Republicans have no bill. That is simply not true, Mr. President.

Just because many of us are not for Clinton-style reform doesn't mean we are opposed to reform or improving our health care system.

Quite the contrary, Mr. President, Republicans are for reform. Look at the numerous bill introduced this Congress on health care reform, and many of them have been sponsored or cosponsored by Republicans.

I have cosponsored several bills that are focused on resolving problems, improving access, retaining what is good in our system, and without increased Government involvement.

These bills have included provisions that would:

Establish medical savings accounts;

Require no new taxes or tax increases;

Reform medical malpractice; and

Reform antitrust laws.

They would reform the insurance market: People could not have their insurance canceled or their premiums increased because they get sick.

They would provide assistance to the poor through vouchers for low-income families: States would be allowed to privatize Medicaid, and low-income families would qualify for subsidies to purchase private insurance, at or below 150 percent of poverty.

They would retain the high quality of care we currently have in this country: There are no mandatory alliances or excessive Government involvement or other provisions that could contribute to a decline in quality.

They would not include employer mandates that would cost jobs;

They would not limit or standardize the benefits people could choose;

They would not limit our choice of health care provider; and

They would improve health care in our rural and frontier areas.

The goal of these private-oriented plans has been to empower the individual to improve the system by maximizing the ability to make choices.

Individuals are certainly better able to determine their needs than the Federal Government, just as experienced health professionals can best decide on the best method of treatment.

We do not need extensive Government intervention to reform our system and improve access to health care.

There are major differences between the Clinton-Mitchell bill and the Dole-Packwood bill. Some of the main concerns I have are as follows:

CLINTON-MITCHELL

Overall, I have concerns about the massive increase in the Federal Government's involvement in our health care system. In my review of the Clinton-Mitchell bill I found a continual theme of boards or commissions in all three versions that would be established to examine and evaluate all aspects of health care imaginable.

With each of the new Government bureaucracies comes a price tag that the American taxpayers will have to cover.

Conservative estimates on the increase in the Federal Government's involvement show that Clinton-Mitchell as originally introduced would create: 50 overall new bureaucracies; 83 new responsibilities for the Secretary of Labor; 175 new responsibilities imposed on States; and 815 new responsibilities for the Secretary of Health and Human Services.

These figures may have changed with the numerous changes that have been made to the bill since the introduction. But even a fraction of these numbers would be unreasonable and oppressive.

Other main concerns with the Mitchell-Clinton bill include:

New and increased taxes: Clinton-Mitchell imposes at least 17 new taxes, including a tax on every health insurance premium. These 17 new taxes will hit: health insurance plans, flexible spending accounts, Medicare beneficiaries, and State and local government workers—not good for the middle class;

The lack of a medical savings account provision: The Mitchell-Clinton does not allow for medical savings accounts [MSA's].

One of the most innovative ideas advanced during the debate on health care reform has been medical savings accounts, a portable fund that can be used to pay out-of-pocket medical expenses and control costs.

MSA's would provide a source of funds for people to keep their coverage continuous during periods of unemployment and would significantly reduce the numbers of short-term uninsured.

MSA's also represent the one idea that has the real potential to reduce health care costs without resorting to the rationing of care and artificial price controls.

Along the lines of cost containment, MSA's also would restore the patient-physician relationship, thus empowering people to become knowledgeable consumers of health care services and would make patients more cognizant of the cost and quality of their care.

Mr. President, early in the 102d Congress Senator Steve Symms and I introduced the Affordable Health Income Tax Act, which would have established medical saving accounts. It was a good idea then and is an even better idea now.

Also, as I mentioned before, my home State of Idaho has passed a statewide provision for medical savings accounts.

Less choice: The Mitchell-Clinton bill contains a Government-defined standard benefit package that will make existing health insurance policies illegal or taxable.

Current employer-sponsored and individual plans that respond to the varied needs of American families would be supplanted by a one-size-fits-all plan designed by the Federal Government, and many self-insured programs would no longer be allowed to exist.

Additional concerns are:

The impact it will have on jobs and our economy;

Price controls on health insurance that will impose taxes on some health insurance plans;

The establishment of a National Health Board;

The ban on self-insured plans for firms with fewer than 500 workers; and

The numerous mandates, including a "triggered" mandate on employers that would be triggered by State in the year 2000.

The Congressional Budget Office didn't seem to think it was such a great idea, reporting that:

> Because of the disruptions, complications, and inequities that would result [from the Mitchell triggered mandate], CBO does not believe that it would be feasible to implement the mandated system in some States but not others.

In fact, Mr. President, CBO's estimate includes a number of references to difficulties in implementing other provisions in the Clinton-Mitchell bill.

The mandate issue is a very important part of this debate, which I intend to discuss in greater detail at a later time on this bill. However, I would like to share with Senators the concerns of one of my constituents who is a small business restaurateur.

In short, he is concerned about maintaining the number of employees he has, the increased financial burden he would face with an employer mandate, and the lack of options to pay for the increased cost. He is in the fast food market, so raising prices is not an options. Mr. President, I ask unanimous consent that my constituent's letter be included in the RECORD.

The impact it will have on our budget deficit, safeguarding the Federal Treasury, not to mention taxpayers' wallets, is hardly the top concern in the Clinton-Mitchell bill. The so-called fail-safe provisions intended to prevent runaway spending are in the very last portion of the bill. They appear to have been tacked on at the end as a sort of hollow salute to questions about spending.

The Clinton-Mitchell bill attempts to control what will be runaway health care spending by requiring the President to make sequesters in health care spending if it goes over budget.

Sequesters are ordered every October 1, if necessary. What's the track record for Congress with October sequesters? This begs the question of what happened to the Gramm-Rudman law. The first cuts—if they ever actually occur—come in premium subsidies, the heart of the program:

Insurance premium subsidies for individuals;

Subsidies for small businesses paying for insurance;

Reduce the tax break for self-employed buying insurance;

Raise the deductible for Medicare prescriptions;

Reduce direct Federal health spending across the board.

Who's the main target when costs rise out of control? In an earlier draft authors of the Clinton-Mitchell plan tripped their hand—increasing Medicare deductibles was the No. 2 target.

SEQUESTER EXCEPTIONS

The Clinton so-called economic bailout package comes to mind. Though the Bush recovery was under way, the stampede for unemployment pork was nearly unstoppable.

Economic projections, on which sequesters could be suspended, can come from either the Department of Commerce or the President's OMB. If you were President, which would you pick?

The National Health Benefits Board is required to issue, "A report including alternative proposals to offset the projected excess." Can you read "higher taxes" between those lines?

Mr. President, there are many more issues to be covered, and in more detail, than I have included today. I fully intend to make further comments as this debate continues.

CONCLUSION

Mr. President, I cannot say strongly enough that this is one of the most important debates that we, as a nation, have ever entered into. There are some who feel a bad bill is better than no bill. I don't happen to agree with that philosophy.

It is important for all of us to be involved in this debate, and I mean the

American people, not just the Congress, because:

Health care is a very personal issue;

Health care reform touches each of our lives;

Health care reform could affect a large portion of our economy;

Health care means taking care of people and their needs;

Health care means jobs.

Mr. President, in closing, let us remember that when most of us were kids and caught colds, we'd stay home from school and get some rest, maybe take some common cold medicine.

That's the way you treat a cold. You take care of it so it doesn't get worse. You don't have x rays and other tests, or surgery. It's unnecessary and wasteful.

That's how I see the Clinton-Mitchell plan for health care reform. It's an amputation, when what we need is some commonsense treatment.

I would close by saying this afternoon that in all of those trips to Idaho and all of those health care conferences and town meetings there has been the emergence of what I believe most Idahoans recognize as the kind of health care reform they want. They want their own choice. They largely want to be able to control their own health care, but they do recognize that there are some overpowering consequences across the country that would cause them to have to ask us to deal with some of the issues.

And those issues they want are the establishment of medical savings accounts. They require no new taxes, so they could have more spendable income to deal with it. They recognize that medical malpractice is a very real problem and that there has to be some tort reform. There needs to be some antitrust law change. And they clearly recognize the need for insurance reform in the broad scale.

I had once said to me very clearly, "If you could get the U.S. Congress to do what the Idaho Legislature has already done, we think you would go a long way towards driving health care down so that it would be increasingly more affordable, not just for Idaho's citizens, but for the rest of the country."

In closing, I think something else that concerns Idahoans a great deal—and I am talking about the primary employer in Idaho, and that is a small business person—is that a Clinton-Mitchell-like bill is going to have to cause them to fire or to release several of their employees so they can provide health care for their other employees. That is a very high risk and, frankly, in my opinion, and in the opinion of an awful lot of others, that is the wrong approach.

So whether it is the Clinton-Mitchell bill, as amended, or whether it is another approach, let us stay here, debate these issues, and understand them in a way that the American people can respond to us as to the type of health care proposal that they want that will ultimately get the majority support here in the U.S. Senate and in the United States Congress, and that can be signed into law.

I thank the distinguished chairman of the Finance Committee for yielding the necessary time for me to conclude my remarks.

Mr. MOYNIHAN addressed the Chair.

The PRESIDING OFFICER (Mrs. BOXER). The Senator from New York.

Mr. MOYNIHAN. Madam President, I thank the Senator from Idaho for a thoughtful and factual account of the situation in the State of Idaho. And I note a thing that might not occur to an Easterner, that the term "rural" does not extend to the reality of the frontier. There are areas legitimately so described and we have to think about them.

But may I say, with respect to this business of bureaucratic organizations, just 3 days ago the Republican mayor of New York, a very distinguished and able man, Mayor Giuliani, in the company of two union leaders, wrote to Mr. GEPHARDT on the House side that: "America is debating universal health care. New York has given universal coverage for most of this century." I make the point that we have done. And that universal health coverage in New York City provides an extraordinarily diverse environment. There are municipal hospitals; there are for-profit hospitals—I think there are some. The greater part of the system is run by private, nonprofit hospitals, most of them either began or continue to be associated with a religious denomination.

We have a large municipal work force that handles these things. But the greater part of the workforce involved is in the private sector. And the coverage is not only good, it is, in fact, the best in the world—not for every individual. But the finest medicine practiced on Earth is practiced in the city of New York.

So there are ways of getting from where we are in the main in the country to universal coverage without a Federal dictate on every detail, and I hope we will find one.

I see the Senator from Hawaii, who made such a striking address the other day about the effects and about the fortunate fit that the universal coverage in health care has had with the growth and prosperity of small business, has risen. I want to note that I was struck by the statistics, by the data he brought to us. I look forward to his remarks and yield him such time as he may desire.

Mr. AKAKA addressed the Chair.

The PRESIDING OFFICER. The Senator from Hawaii.

Mr. AKAKA. Madam President, I thank the chairman for yielding time.

Madam President, it appears that there are those who feel afraid that the success of Hawaii's health care system represents too good an example when used by the proponents of meaningful health care reform. During the past week, we have witnessed the dissemination of misleading and erroneous information about the effectiveness of the Aloha State's health care system and, more particularly, its impact on small business.

The health care system is being blamed for supposedly some of the problems in businesses that Hawaii has had. I want to present some facts here that will allude to this. Let me give you just one example.

As they have in recent weeks, and they did again this morning, the National Federation of Independent Business cites a jump in 1992 business failures and 1993 job losses in Hawaii and implies that these events are somehow related to the Hawaii Prepaid Health Care Act.

Do you find this to be strange, to pick two different indices from two different years to illustrate the supposed evils of a 20-year-old program?

It is not so strange when you note that the NFIB fails to mention one other "very small" concurrent event of that unfortunate time for local businesses. That event was the September 1992 billion-dollar devastation of Hurricane Iniki, whose economic impact was felt well into 1993 and is still being felt today.

Let us get some basic perspective on this, Madam President. Hawaii is not the small business black hole of the universe. The facts are simply these: According to accepted small business indicators, Hawaii ranges from being far better than the national averages to—at the very least—on par with the rest of the country. At the same time, we are the only State that requires the employer and employee to contribute to health insurance coverage. The point is, shared responsibility is not the fear of some poison arrow it is characterized to be by those who oppose serious health care reform.

At this time I feel that I must address the scare tactic information being spread, so let me just direct your attention to two matters of Hawaii's Prepaid Health Care Act history that I believe are of special interest because they mirror so well what we are now going through on the national level today.

First, when Hawaii's Prepaid Health Care Act was being considered, it was opposed—it was opposed—by the Employers' Council, the chambers of commerce, and a raft of small business associations. They were afraid of the economic consequences, and no reasonable person could have blamed them at that time. Naturally, the greatest concern by far was the potential impact on small businesses, the lifeblood of our economy. As a result, the Hawaii Prepaid Health Care Act specifically

sought to ensure adequate protection, especially protection for the most vulnerable of all small businesses, those with less than eight employees, the little mom-and-pop operations.

The act established the premium supplementation fund to provide small business relief, and $375,000 was set aside solely for that purpose. Today, in 1994, without any further appropriation having been made in the last 20 years, the fund now stands at $2.5 million. Assistance was applied for by only five businesses during that time, and paid for by the fund over two decades, and that amounted to a total of $110,000. There has been no apocalypse.

My second example of deja vu all over again is this. All of the groups I previously mentioned were joined in their opposition to the Prepaid Health Care Act by, among others, the Hawaii Medical Association. Here is an excerpt from the HMA's testimony in 1973:

The national Government is already moving in the direction of a national health insurance program which seems likely to become law within the next year or two. It would seem foolish for the State of Hawaii to embark on a program that would perhaps be superseded by Federal regulation within a short period of time.

At that time, HMA, the Hawaii Medical Association, felt that a Federal national program was going to happen in 2 years. Here it is, in 1994, and we still have not had one. And we need it today.

The Medical Association recommended that we not proceed with such major reform, but that we defer action. Does that not sound familiar? You bet. Fortunately, Hawaii had the courage to act and not wait. And Hawaii, indeed, became the health State of our country.

Our country cannot afford to wait. We must have the courage to pass a universal health care act. Our people need it. It is the best thing for our country at this time. And I urge my colleagues to support this act.

Mr. MOYNIHAN. Madam President, may I once again thank the Senator from Hawaii, who comes to the floor with experience and with facts. Some have experience; some have facts. But singularly, the State of Hawaii represents both. And we are grateful for that.

I see the Senator from South Dakota. I am happy to yield him 5 minutes. Would that be helpful?

Mr. DASCHLE. I thank the chairman. I appreciate his yielding me time.

Madam President, what is the pending business?

The PRESIDING OFFICER. S. 2351, and the question is the Dodd amendment.

Mr. DASCHLE. The Dodd amendment is the pending business?

The PRESIDING OFFICER (Mr. AKAKA). That is the pending question, to the Mitchell substitute.

Mr. DASCHLE. Mr. President, I asked that somewhat rhetorically, there has been very little discussion today of the Dodd amendment. We have heard many long and very eloquent speeches about health reform. Members on both sides of the aisle have indicated their positions. But the amendment of Senator Dodd now has been pending 4 days. I think the message in all that is we have waited and waited, accommodated and accommodated. The majority leader has laid down a proposal, now 2 weeks tomorrow. He introduced the proposal 2 weeks ago tomorrow—2 weeks ago, August 2. On August 3, he introduced the bill. That was Wednesday, 2 weeks from this coming Wednesday.

On August 9, the floor debate began. That was Thursday. The Republican leader asked for a week's delay to be able to look at that. The majority leader accommodated that request. They requested no votes to be taken last Monday and Tuesday to study the bill. That request was accommodated. There was a request that no amendments to health reform be voted on last week. That, too, was accommodated. We were told that no votes would be allowed last Saturday; no votes would be allowed today. Yet, with speech after speech, requests are made to seek yet additional time to talk about the bill.

My question would simply be, if you do not like the bill, where are the amendments? I hope we can get to work. We have accommodated every single request from Members on the other side, every one. I hope we can go to some votes and finally get on with the real nuts and bolts of trying to improve the bill, change the bill, do whatever we are going to do with the bill. But let us get to work. We have waited now 2 weeks. The last time we went to war, it did not take this long.

So I hope we could get on with some constructive debate, that we could talk about amendments, we could have a vote on the Dodd amendment.

There are many other amendments pending, at least on our side. We could go to those votes. But let us get on with it. I think the American people expect us to finish this legislation. I hope we can do it sometime prior to Labor Day. But with each passing day, with each passing additional request, I become increasingly pessimistic, frankly, about whether we are ever going to be able to get to amendments.

Let us vote.

Mrs. BOXER. Will the Senator yield?

Mr. DASCHLE. I am happy to yield to the Senator from California.

Mrs. BOXER. Mr. President, I thank the Senator from South Dakota for his leadership in bringing us back to the matter at hand. As a matter of fact, the Senator from Hawaii was kind enough to take the chair for me for just a moment so I can say to the Senator how pleased I am he reminded the Senate that we have been supposedly debating this first amendment for many, many hours.

I say to the Senator, according to the numbers I have, approximately 12 million Americans under the age of 21 do not have health insurance—12 million young Americans. I have been in the Senate for a couple of years, in the House for 10 years, and the Senator and I have served for a long time together. I have heard the most eloquent speeches from both sides of the aisle in all those many years about how children are our future, and if we do not care about the children, what is going to happen to America?

I would say this is the moment to stop the talk and start to vote for the children of this country. It is absolutely immoral not to cover the children. It is also economically insane not to do it. We know every dollar we spend on immunization saves $10. We know when we give prenatal care, we save money and we get healthy babies. This is an amendment that deserves to be voted on.

I just ask the Senator a question, since I must do that under the rules, and that question is: Does the Senator feel—and I ask because he has been in such a leading role in this, along with Senator KENNEDY—does the Senator form a sense from the other side of the aisle that we are moving together in a bipartisan way to begin voting on this bill?

Mr. DASCHLE. Mr. President, I wish I could answer in the affirmative to the Senator from California, but the fact is, I do not. We still do not have a commitment from the other side to allow us a vote on the Dodd amendment. This is the fourth day now that we have debated the Dodd amendment, although there is very little discussion about the Dodd amendment from the other side. This is an important amendment. Senator DODD made a very compelling case for its passage. I believe in other circumstances, there would be strong bipartisan support for it.

The Senator has indicated there are a lot of people who are really riding on the decisions we are making here; 48 people every minute lose their health insurance, so with every 10-minute speech, we have 480 additional people who have lost health insurance in that period of time.

How many people, day after day over the last couple of weeks, would have been covered, would have been protected, had we been able to enact this legislation months ago?

So I am pleading, at some point in the not-too-distant future, that we get on with it, we go to work, we offer amendments, we have votes. If there are differences of opinion, let us work them out. If there are ways by which we can improve the Mitchell bill, let us work them out. Let us offer amendments and resolve these differences. Let us go to work.

I yield the floor.

Several Senators addressed the Chair.

The PRESIDING OFFICER (Mrs. BOXER). Who yields time?

Mr. PACKWOOD. Will the Senator yield for a question?

Mr. MOYNIHAN. Certainly, I yield for a question to my friend.

Mr. PACKWOOD. Madam President, the question is as follows: Did Senator MITCHELL not indicate—and I am quoting—"There will be ample opportunity to debate this bill. I have said many times no one will be rushed. We will stay here as long as it takes, as many days, weeks, months as necessary for every Senator to be able to consider the bill amply?"

I think Senator MITCHELL said that, and there are still many Senators who want to discuss this bill amply.

Mr. MOYNIHAN. Which we understand.

Mr. COATS. I wonder if I could also ask a question of the Senator from South Dakota.

Mr. MOYNIHAN. I am afraid our time is constrained by the 5 o'clock cutoff. The Senator from Missouri wishes to make his opening statement. So I yield 5 minutes to the Senator from Massachusetts, our champion from Massachusetts.

The PRESIDING OFFICER. The Senator is recognized for 5 minutes.

Mr. KENNEDY. Mr. President, I want to join in the, I think, compelling question that has been raised by the Senator from South Dakota and the Senator from California. The issue about children is an issue that is well understood by the Members of this body.

We are a country that has one of the highest infant mortality rates in the world, and this has been stated and restated and restated on both sides of the aisle. We have one of the highest incidence of low-birthweight babies in the world and this has been stated by Republicans and Democrats. We produce about 80 percent of the world's vaccine, and we still have one of the poorest records in terms of vaccinating children throughout the country. And this is a real problem.

Time after time we have had demonstrated on the floor of the U.S. Senate what is happening in other countries of the world, countries that have standards of living similar to ours and have had health insurance, universal health coverage. What has happened when they have given focus and attention to preventive health care programs for their children? Their children grow, their children blossom, their children are healthy. They have seen the savings that have been out there in terms of financial resources and the savings that have been there in terms of health challenges. Day in and day out, it is uncontroverted.

What the Senator from South Dakota and the Senator from California and the Senator—I am sure—from New York and I are saying is, let us get about the business of just having the vote on that particular measure and then get on with other areas, get on to other provisions of the legislation. But the majority leader, when he was out here the other night, said, fine, all right, go ahead and have equal division of time on Saturday, but maybe we will get some kind of answer if we can talk and find out whether we can vote on the basis of either the Dodd amendment or the other three or four amendments which have been shared, as I understand it, with the minority leader; that we were prepared to move ahead on and we were hopeful that on Saturday we would get some indication.

Now we are here in the late afternoon on the floor of the U.S. Senate on an amendment that is understood by the Members, all the Members of this body, and unquestionably will make a significant and important difference to the children of this country. The only responses are: Other Members want to make opening statements; other Members want to talk at length; other Members want to get off their chest, and say what is on their minds on health care.

When are we going to say that the children are the important ones and call the roll on that issue, and let us get about the business of what this debate should be about, and that is making some judgments?

Maybe this amendment will not carry. I think the compelling case has been made for it by the Senator from Connecticut and the other Senators who have spoken for it.

All we are asking is, let us shorten our speeches and try to take some action. I think the American people would applaud that action. I understand what the Senator from Oregon is saying, that we are going to have day after day after day after day of long speeches, and we wonder why people back home do not believe that this institution is relevant.

The issue is children; the issue is preventive care; the issue is their future and whether they are going to have a bright and hopeful and healthy future, and do it in a way that is going to save money. We ought to be able to agree on that.

I would think that we could go shorter on the long and extended speeches that have been talked about, I think even threatened. Talk about Senators wanting to talk 3 and 4 hours—we have to ask ourselves, do the American people think this institution is better served by Senators speaking 3 or 4 hours on these matters of general subject, or taking action for children?

Mr. COATS. Will the Senator from Massachusetts yield to me for a question?

Mr. KENNEDY. Whatever time I have, I will gladly yield for a question.

The PRESIDING OFFICER. The Senator has spoken for 5 minutes. The Senator from New York controls the time.

Mr. MOYNIHAN. I do not want to be in any way discourteous, but the Senator from Missouri has been very patiently waiting.

Mr. COATS. I will propound it at a different time.

Mr. KENNEDY. I will be around.

Mr. MOYNIHAN. He will be around. As soon as we vote at 5 o'clock, we resume debate.

Madam President, I am happy to yield the remainder of our time to the able and learned Senator from Missouri, who is one of those who helped pass the Finance Committee's bill out of committee.

The PRESIDING OFFICER. The Senator from Missouri is recognized for 34 minutes.

Mr. DANFORTH. Madam President, I thank my chairman.

I will offer my view of where we are in the health reform debate and how I think we should proceed from here. Maybe I am the only person in the Senate who feels this way. But I will unburden myself of my thoughts.

Right now we are hopelessly bogged down. We, not only being the Senate, but the Congress and, indeed, the country. We are hopelessly bogged down on the question of health care reform legislation. I do not think we are going to get moving by continuing to spin our wheels on the floor of the Senate by proceeding from amendment to amendment.

I think that there is one answer, and that is that we regroup, and attempt to come up with a consensus health care reform proposal that can be passed. It is my judgment now—and it has been my judgment for a very long time—that where we are going to end up is approximately where Senator CHAFEE has been for about 4 years now. Therefore, I think that if we are going to pass health care legislation this year, it should be a bill which is somewhere in the neighborhood of the effort that is now underway in the various meetings being held by Senator CHAFEE and Senator BREAUX, and others, who have styled themselves as the so-called mainstream coalition.

Let me say that there are, obviously, a whole variety of opinions in the Senate. There are people who think that we should pass no legislation; either we should pass no legislation at any time or we should pass no legislation this year because when the election comes, the makeup of the Congress will be changed. On the other hand, there are people who think we should pass very sweeping legislation and the sooner we do it the better.

However, I believe there is a strong core group in the middle in this Congress and in the country that believes that we should pass legislation, that

we should attempt to reform health care, but that what we should do is avoid the extremes that have been presented to us.

The interest in health care reform legislation on the part of Senator CHAFEE and those who have rallied around him is not something that has begun in the last few months. It did not even begin with the Clinton administration. It began 4 years ago.

Four years ago, our Republican leader, Senator DOLE, with, I think, great foresight, saw that health care was going to be a coming issue, and he asked Senator CHAFEE to chair a task force of Republican Senators to address the question of health care.

Senator CHAFEE has done that with great determination. Virtually every Thursday morning while the Senate has been in session, over a 4-year period of time, Senator CHAFEE convened a meeting in his hideaway office to educate Republican Senators on the question of health care.

Those meetings were held in a very systematic fashion, well prepared in advance. And normally there were 15, 20, 25 Senators who would show up at 8:30 on Thursday mornings for an hour to discuss health care and various aspects of health care.

Then, after a period of time—years really—we finally put together a bill. This bill was introduced by Senator CHAFEE and it had something like 19 or 20 Republican cosponsors.

The ideas in that bill have continued to be the views which have been held by the mainstream coalition, a group of people consisting of Republicans and Democrats. It is something of a changing group, but last week we had up to 16 Senators, just about evenly split between Republicans and Democrats, who showed up at our meetings. The basic ideas of the Chafee legislation have been at the heart of what we have been discussing and, in fact, were at the heart of the bill that was reported out of the Senate Finance Committee about 5 or 6 weeks ago.

What are those ideas? Universal coverage, but universal coverage achieved as and when Government can pay for the subsidies that would undergird universal coverage; insurance reform to assure portability and to assure that people who become sick are not dropped from insurance coverage; cost control, not by price control or premium caps, but cost control achieved by enhanced competition, with a view that a competitive marketplace works better than Government; control of Government spending through a failsafe device which provides that we are not going to have the runaway spending by the Federal Government which has characterized Government health care spending for the past couple of decades; and significant medical malpractice reform.

These were the core concepts of the Chafee legislation, and these have been the core concepts of the mainstream group that has been meeting. I believe they are good concepts and sensible concepts, and I do not believe they are the kinds of ideas that frighten the American people.

One of the significant things about these meetings is the attitude that has been manifested in them. Go to the floor of the Senate and obviously there is a lot of contentiousness. But back in the hideaway office of Senator CHAFEE, when we meet for a couple of hours at a spell, Democrats and Republicans, the basic attitude is one of cooperation and attempting to seek mutual understanding.

But there is something else that characterizes those meetings, and that is nervousness, nervousness that we are dealing with something very big and very important, nervousness that we are dealing with the whole health care system of this country, nervousness in knowing that what we are touching is something that affects the lives of every American, nervousness and worry that maybe we are going to make our health care system worse, not better, and nervousness about the budget, the cost of health care, and the concern that already our Federal budget is spinning out of control.

So there has been a lot of goodwill in those meetings and there has been a lot of nervousness. And I think the nervousness is important as we proceed with this legislation because we do not want to do something that is terrible for the country. The basic feeling of the group, and the basic feeling that is obviously shared by a lot of Republicans because they have been making speeches on it in the last week, is we just do not think the Mitchell bill is a very good bill. We think it is too big, that it goes too far. And so I would like to talk about the Mitchell bill, not in a partisan way, but simply to point out where it differs from where we are and from what we think in our group.

Now, much of the discussion in the media about the Mitchell bill, and the Clinton bill, and the Gephardt bill, and the Dole bill has been on the subject of universal coverage, and particularly employer mandates. In about 1 minute I am going to stop talking about employer mandates.

One of the interesting things about our meetings is that almost no time have we spent talking about employer mandates. That may be an exaggeration, but I would say maybe 5 percent of our time, and no more than 5 percent of our time, have we spent on the subject of employer mandates. But if you read the newspapers, you think that is all we talk about, that is the only subject.

So when Senator MITCHELL introduces his new legislation, and he seems to be making compromises on the subject of employer mandates, the way that is covered in the media is, "Well, Senator MITCHELL has come our way, and he has met us halfway. Isn't that good? We are on the brink of compromise."

He has not met us halfway. We are light years away from Senator MITCHELL. He has come closer to us on employer mandates, but not on other subjects. Then, when, I have tried to make that point to the media, the conclusion is, well, these mainstream people do not care about the employer mandate idea, or they have given up on that. Well, there are a variety of opinions among our 15 or 16 Senators on the question of employer mandates. But I think it would be fair to say that most of us do not like the idea. We do not think it is a good idea. We do not think it should be included in the legislation. But my point is that that is a fraction, and a small fraction, of the total issues before us.

Now, what are these other major issues? I would like to talk about them.

The first question is cost. Cost. First of all, cost with respect to the Federal Government—the cost to the Federal Government of this program is thought to be in the neighborhood of $1.2 trillion of new Government spending on entitlement programs over the next 10 years—$1.2 trillion of new entitlement programs over the next 10 years. That is a lot of money. Every program that we are talking about—the Dole program, the Chafee-Breaux program, all of these have more spending on at least one entitlement, and that is subsidies for low income people to help them purchase coverage. But the problem with the Mitchell program is that it is just too much. It is too extreme. It does not start with one new entitlement program, a subsidy program for low-income people, but adds all kinds of other entitlements and some very big ones:

Prescription drug benefit. Is that a good idea?

Well, helping people pay for prescription drugs, who can argue with that? But it is expensive—$95 billion over the next 10 years.

Home health care. Is that an important thing to do? You bet it is. And I say that as the father of a home health care nurse. But can we afford $48 billion for home health care? I would suggest that the answer to that question is no, not now.

I want to point out with a chart that I have here why I think the answer to the question has to be no. Senator BOB KERREY and I are the chairman and the vice chairman of the bipartisan Commission on Entitlements. This is a very striking chart because it shows what is now happening in Federal Government outlays as a percentage of gross domestic product. The green line shows the rate of taxation in our country, which has hovered at about 18 or 19 percent since the 1970's.

What this chart shows is what is happening to Federal spending. The fact of

the matter is that by the year 2012, entitlement spending plus interest on the national debt will consume all of the money that we raise in Federal taxes in our country. By the year 2012—18 years from now—entitlement spending and interest on the national debt will spend everything we raise. There will be nothing left, other than borrowed money, for everything else that we do as a country.

Take national defense, some people say we spend too much, some say we spend too little. Assume we spend nothing on national defense. We have a crime bill. Some people will say that is too much to spend on a crime bill. Assume you close down all the prisons; assume you close down the court houses and you close down the FBI. That is what we would have to do. There would be nothing for national defense, nothing for crime, nothing for highways, airports, the environment, and whatever else we do as a country. All of it would be consumed by interest on the national debt, plus entitlements.

By the year 2030, four entitlement programs—Social Security, Medicaid, Medicare, and the Federal retirement program—will consume all of our revenues. We will not even be able to pay for the interest on the debt. There will be nothing left over.

So that is why I think we have to be very careful about getting into new entitlement programs.

Are they popular? Of course, they are. That is why we do them. Yes, they are popular. But how much can we do? We cannot afford $1.2 trillion in new entitlement programs, no matter how wonderful they are.

So, from a cost standpoint, I believe that the Mitchell program is just too expensive.

A number of Senators have talked about the additional bureaucracy. More than 30 new Federal agencies or commissions are created by the Mitchell program. It is too much; it is just too much for us to choke down as a country. It is too much. It is too big. If we are going to pass health care legislation, we are just going to have to get off of this Mitchell bill. And I do not say that in a disparaging way to the majority leader. I am just saying it is too much. It is not going to be passed. We have to cut it down to a reasonable size, and to a reasonable concept. That is what Senator CHAFEE and Senator BREAUX and others, on a bipartisan basis, have been trying to do.

Let me make some additional comments about the Mitchell bill and where it differs from our legislation. Again, I am not even getting into the subject of employer mandates. But what I want to make clear is that there are other big areas where we believe that the Mitchell bill is just wrong. I want to underscore the fact that I do not think it can be amended back into shape. I think we are going to have to start with something new. I would recommend that it is the Chafee approach.

First of all, with respect to cost containment, cost containment has a couple of aspects to it. One is cost containment relative to the chart that is behind me now. The Federal Government costs: How do we contain the Federal Government cost of health care?

Senator MITCHELL has a proposal to do that, so he says. Senator CHAFEE and Senator BREAUX and the so-called "mainstream group" have a very different kind of proposal. The basic problem with Senator MITCHELL's proposal is that he excludes from the purview of cost containment existing Government health care programs, and the Chafee-Breaux approach includes within cost containment existing Government health care programs.

That is the big difference. Should they be included or should they be excluded? Should Medicare, which is the biggest one, just be excluded? Should there be a constant debate on whether or not the increased cost of health care is caused by the legislation that we may be about to pass, or by an existing program?

Should that kind of gaming of the system be part of the ongoing national debate on health care? Or, instead, should the so-called fail-safe device for making sure that whatever we do is not going to create a worse budget deficit than we have right now, should that apply to all of health care? That is the issue. Our view is quite different from Senator MITCHELL's view on the design of fail-safe.

The second big question pertains to the cost of health care, not just from the standpoint of the Federal Government, but from the standpoint of the Nation as a whole. Some people do not want any cost containment. Some of my Republican colleagues really do not have cost containment in their legislation. That is popular, I know. It is good politically. But it is not really responsible.

So if you believe that there has to be some way of containing the cost of health care, not only for the Government, but for the country as a whole, how do you achieve that cost containment? How do we put together the kind of legislation designed to control the cost of health care?

Again, there is a very different approach between the Chafee-Breaux idea and the Mitchell idea. The Mitchell idea is very close to price controls, to premium caps. Senator MITCHELL's bill would tax the increase in cost of health care. It would tend to lock in—almost grandfather—high-cost existing plans, ratifying them, and then create a Government formula for taxing increase over a set rate.

It is our view that low-cost plans would be penalized if that kind of calculation were put into place. It is also our view that to tax increases is very much like a premium cap. It is a premium cap using a tax mechanism as the device to accomplish the premium cap.

The Chafee concept is designed to enhance competition between plans, between insurance companies; to create competition so that insurance companies are competing with each other to try to keep the cost of insurance down for the American people.

That is a very shorthand way of explaining the difference between the two. The Chafee idea is closer to a tax cap. The Mitchell idea is closer to a premium cap. The Chafee idea builds on competition. The Mitchell idea builds on Government control. They are philosophically different. We believe that the Chafee plan is much, much better.

What are some of the other problems with the Mitchell proposal, as we see it? One set of problems is what the Mitchell plan does to health care networks such as health maintenance organizations.

One thing it does is to mandate that these health care networks have to contract with what are called the "essential community providers" and the essential community providers are defined in a very sweeping way. What it says is that these networks which are supposed to be competing and trying to keep prices down are required by Government to do business with various hospitals and health care organizations which they might not want to do business with.

You cannot have a market system that works effectively when you tell people who are trying to work within the market that you have to do business with people who you do not think are very good; or you have to have large numbers of institutions as part of our program that you do not necessarily want, or even very high-cost institutions. Furthermore, the Mitchell bill causes health plans to have to hire every type of specialist, even if the health plan does not think that the specialists are needed and even if they are costly.

There is another big problem we see with the Mitchell plan: Litigation. We thought that trying to get a handle on litigation was essential to health reform. It is estimated that defensive medicine costs $25 billion a year in the United States—just doctors and hospitals trying to prevent lawsuits. And access to medicine is affected by the litigation explosion. Take, Howell County, MO; the county seat is West Plains. Nine counties surround Howell County, some in Arkansas and some in Missouri. In these nine counties, there is nobody that will deliver a baby except at the West Plains Hospital. Nobody will deliver a baby because people who have done it are out of that business. It is the lawsuit explosion that

has done this. To deal with this, we have real malpractice reform in our legislation. We provide real incentives for alternative dispute resolution. Senator MITCHELL does not. He has alternative dispute resolution, but it is add-on litigation. There is no incentive built into it to use alternative dispute resolution. We have that incentive.

We have caps for noneconomic damages. We have real reform for the punitive damage system so that it is something more than a windfall for attorneys. Senator MITCHELL scraps all that.

This is not just a matter of trying to further amend the Mitchell bill. His whole bill is wrong. And crammed into that bill are all kinds of incentives for litigation. He has so-called anti-discrimination provisions. He has major, major changes in the civil rights laws of the United States contained in his legislation. I know something about civil rights laws, because in 1990 and 1991 I spent the better part of 2 years of my life working on what became the Civil Rights Act of 1991. That whole legislation would be changed in this health care legislation. We took 2 years working on it and, believe me, it was tough going. Now we have in the health care legislation major changes.

For example, we cap both punitive damages and compensatory damages in our current civil rights law. In the Mitchell bill there is no cap—unlimited compensatory and unlimited punitive damages for lawsuits—and there is an expansion of the groups that are protected by civil rights laws in the United States. Under his bill, there would be causes of action on the basis of language, or income, or sexual orientation. That is a big change in the civil rights laws. Some people might say that is good. But what does it mean? Does it mean that, henceforth, hospitals have to have interpreters in the hospitals? Say, in California, where our Presiding Officer resides, are the hospitals supposed to have, for all the various nationality groups that live in California, interpreters or they will risk a lawsuit? How about income discrimination? We have had hospitals in my community of St. Louis that have moved. Saint Luke's Hospital, for example, and DePaul Hospital have moved from the city of St. Louis to St. Louis County. If they were to do that in the future, would they be sued because they were violating civil rights laws? I think that the answer is clearly, yes, they would be, under the Mitchell legislation.

And then there are the Section 1983 Actions. I spent 8 years of my life as a State attorney general, and Section 1983 was the biggest problem I had as State attorney general. These are civil suits against State and Federal officials. In 1993, there were 51,000 civil rights suits filed under Section 1983 against the Federal Government. In general, 10 percent of the cases pending in State attorney generals' offices are Section 1983 cases.

This Mitchell bill has a major expansion of civil rights causes of action, so that lawsuits will be filed against the Federal Government and the State government, as well as against insurance companies, insurance plans, employers and the like. And the so-called Mitchell-3 provided yet another new cause of action against health plans and purchasing co-ops if they fail to carry out their responsibilities under his bill.

Graduate medical education. Do we really want a national council on graduate medical education telling us how many physicians we should train and in what specialties and in what hospitals?

So, Mr. President, these are some of the problems with the Mitchell bill. I do not state them because I want to pick on the bill that is before us. I simply want to make one fundamental point: This thing cannot be passed. It cannot be passed. We could be here for the next 2 months. We could come back for a lame duck session and start again next year. It is too big, it is too much, it is too expensive, it is too bureaucratic, and it is way too litigious.

So where do we go from here? I believe that the answer to that question is within this mainstream group. I believe that it is not too late to put together a bill that can be enacted into law if we stick to the principles where we can build consensus, and that is my recommendation.

I think we should go back to the drawing boards. We are at the drawing boards and we hope to have legislative language, possibly tomorrow, with specific recommendations.

This underlying bill that is before us now is never going to be amended to a point where it is not something that scares the willies out of the people of this country, and for good reason. It is just too much for us as a country to choke down.

VOTE ON MOTION TO INSTRUCT SERGEANT AT ARMS

The PRESIDING OFFICER (Mr. FEINGOLD). Under the previous order, the hour of 5 p.m. having arrived, the Senate will now vote on the motion to instruct the Sergeant at Arms to request the presence of absent Senators.

The question is on agreeing to the motion of the Senator from Maine [Mr. MITCHELL] to instruct the Sergeant at Arms to request the attendance of absent Senators. On this question, the yeas and nays have been ordered, and the clerk will call the roll.

The bill clerk called the roll.

Mr. FORD, I announce that the Senator from Delaware [Mr. BIDEN], the Senator from New Jersey [Mr. LAUTENBERG], and the Senator from Georgia [Mr. NUNN], are necessarily absent.

Mr. DOLE. I announce that the Senator from New York [Mr. D'AMATO], the Senator from Alaska [Mr. MURKOWSKI], and the Senator from Wyoming [Mr. SIMPSON], are necessarily absent.

The result was announced—yeas 78, nays 16, as follows:

[Rollcall Vote No. 287 Leg.]

YEAS—78

Akaka	Exon	Lugar
Baucus	Feingold	Mathews
Bingaman	Feinstein	Metzenbaum
Bond	Ford	Mikulski
Boren	Glenn	Mitchell
Boxer	Gorton	Moseley-Braun
Bradley	Graham	Moynihan
Bryan	Grassley	Murray
Bumpers	Gregg	Packwood
Burns	Harkin	Pell
Byrd	Hatch	Pressler
Campbell	Hatfield	Pryor
Chafee	Heflin	Reid
Coats	Hollings	Riegle
Cochran	Hutchison	Robb
Cohen	Jeffords	Rockefeller
Conrad	Johnston	Roth
Coverdell	Kassebaum	Sarbanes
Craig	Kempthorne	Sasser
Danforth	Kennedy	Shelby
Daschle	Kerrey	Simon
DeConcini	Kerry	Stevens
Dodd	Kohl	Thurmond
Dole	Leahy	Warner
Domenici	Levin	Wellstone
Durenberger	Lieberman	Wofford

NAYS—16

Bennett	Helms	Nickles
Breaux	Inouye	Smith
Brown	Lott	Specter
Dorgan	Mack	Wallop
Faircloth	McCain	
Gramm	McConnell	

NOT VOTING—6

Biden	Lautenberg	Nunn
D'Amato	Murkowski	Simpson

So the motion was agreed to.

The PRESIDING OFFICER. With the addition of Senators voting who did not answer the quorum call, a quorum is now present.

Mr. MITCHELL addressed the Chair.

The PRESIDING OFFICER. The majority leader.

Mr. MITCHELL. Mr. President, if I may have the attention of Senators?

Mr. LEAHY. Mr. President, the Senate is not in order.

The PRESIDING OFFICER. The Senate will come to order.

The majority leader.

Mr. MITCHELL. Mr. President, several Senators have inquired about the schedule for this evening and thereafter, with respect to this legislation.

First, to recapitulate, I introduced legislation on Tuesday, August 2, 2 weeks ago tomorrow. On Tuesday, August 9, 1 week ago tomorrow, the Senate began debate on health care reform. There were 4 hours of debate on Tuesday, 4 hours on Wednesday, 4 hours on Thursday, 4 hours on Friday, 7 hours on Saturday, and more than 7 hours today.

The first amendment was laid down on late Tuesday afternoon. Notwithstanding that, there have been no votes on any amendment. I initially requested that there be a vote scheduled on the first amendment on Saturday,

but the distinguished Republican leader advised me that Republicans would use their right under the rules to prevent a vote from occurring by making statements. I then requested that there be an opportunity for a vote on that amendment today, and I received the same reply.

It is my desire to accommodate as many Senators as possible with respect to the schedule, but also to recognize that our paramount responsibility is to act on the matters before us. And, therefore, in an effort to reach a conclusion that gives all Senators fair notice of the manner in which we will proceed, and also attempt to make progress, there will be no further votes this evening. The Senate will remain in session for as long as Senators wish to debate. I want to emphasize that point because, although we were told last week that there were a large number of Senators who wanted to speak, not long after we announced there would be no more votes on Friday, all of those Senators left.

And then on Saturday, although I offered to stay in session for as long as Senators wished to speak, the session terminated at about 5 o'clock. So those Senators who have stated a desire to speak, please be aware that the Senate will remain in session for as long as possible—as long as anyone wishes to speak this evening.

We will resume the debate at 9:30 tomorrow. And if we have not been able to have a vote on an amendment by tomorrow evening, then the Senate will remain in continuous session thereafter, through the evening, through the night. If there is going to be delay, then those Senators who are going to delay will simply have to be here around the clock to do it.

I hope that does not occur. I hope we can get to the amendments; all Senators who have amendments will offer them.

But to repeat, in summary: In an effort to accommodate all of the conflicting concerns and interests here, and so as to give Senators full notice and not take any precipitous action, there will be no further rollcall votes this evening. The Senate will return to debate this matter at 9:30 tomorrow morning. And if, by tomorrow evening, we are still in a situation where no votes have been permitted on amendments, then the Senate will simply remain in session on a continuous basis thereafter.

I thank my colleagues and I yield the floor.

The PRESIDING OFFICER. The Senator from Oregon.

Mr. PACKWOOD. Mr. President, if I might respond to my good friend from Maine, at least the chairman of the Finance Committee and I were here until 9:30 on Friday night. And there were speakers going on. We were here 7 hours on Friday. I do not think there has been a quorum call.

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This is not a question of delaying. But the majority leader indicated several days ago that we would have ample opportunity, and every Senator would not be rushed and they could say what they wanted on the most important bill we have seen in a quarter of a century. But we have not wasted time in quorum calls. We have had our people here to speak. As a matter of fact, we used up all of our time ahead of time today, and the chairman was very kind to give Senator DANFORTH part of his time.

If what you are saying is because Senators want to speak—and these are simply opening statements; they have not started to speak on title I, title II, title III, on taxes or mandates or risk adjustment or anything else—are you suggesting, if they want to speak, are you going to force them to speak 24 hours a day?

The PRESIDING OFFICER. The majority leader.

Mr. MITCHELL. I think Senator PACKWOOD's position was made clear when he announced the other day that there were 27 Senators who wished to give speeches of 3 or 4 hours in length, opening statements.

Second, what I said with respect to Friday was that shortly after the announcement was made that there would be no more votes, that Senators left, indicating that the desire to speak was outweighed by the desire to leave——

Mr. PACKWOOD. Except we did speak——

Mr. MITCHELL. As soon as it was announced there would be no more votes.

Mr. PACKWOOD. There may have been no more votes, but——

Mr. MITCHELL. If I might finish? Then, as the Senator will recall, he and I had a colloquy with respect to the schedule on Saturday. I offered to remain in session for as long as Senators wished to speak. He indicated that he did not wish that we remain in session beyond 5 p.m.

I am not attempting to foreclose anyone from speaking. But if that is to be used as an excuse to prevent any action from occurring on any amendment on this bill, then I think we must recognize it as such and deal with it.

Second, the fact that we vote on an amendment or amendments does not mean that a Senator is thereafter precluded from speaking on the bill. We are going to be on this bill for weeks, and every Senator is going to have ample opportunity to address the matter.

But, of course, if, as the Senator said, 27 Senators want to give each a 4-hour speech, why, that is 110 hours right there, which is nearly 2 weeks of regular sessions. If that is the case, it seems to me there is no alternative but to stay in longer than 5 o'clock, 6:30, or 7 o'clock. Otherwise, we would be accepting a condition where we would have a period of several weeks in which there would be a series of 24-hour speeches, and I think that it is better to recognize the situation and deal with it as it exists.

So my view is that we ought to proceed. We have had a lengthy period of opportunity for statements to be made. No one will be precluded from making a statement after the first amendment is voted, between the first and second amendment, after the second amendment is voted and I believe that everyone will have that opportunity. But I do not think we can continue indefinitely in a situation where there can be no vote on any amendment and we simply continue with these statements.

Mr. NICKLES. Will the majority leader yield?

Mr. MITCHELL. Certainly.

Mr. NICKLES. This is the proposal—correct me if I am wrong—that just came out, the latest Clinton-Mitchell proposal 3. This has been in print, what, since Saturday? Saturday is the first day this it was available to Senators?

Mr. COATS. Friday at 5.

Mr. NICKLES. I am informed by Senator COATS Friday at 5. There are significant changes—correct me if I am wrong—there are significant changes between this proposal and the previous proposals.

Mr. MITCHELL. There were a total of five changes, some of them changing one word. All of the changes were listed on a single sheet of paper.

Mr. NICKLES. If the majority leader will yield, to give an example, I did a lot of homework on the leader's proposal, but it was on the first proposal on things like nonconformance to standard benefit plans and there was a 35-percent penalty for nonconformance. I have been told by my staff today that was replaced by a $10,000 civil penalty.

My point being, I have not raised that on the floor because I want to study it a little bit more. We have only had this, I guess, Friday evening—most of us have seen this proposal on Monday for the first time. This is the most expensive or extensive expansion of Government proposed in a long time.

I see a list of 133 changes that were made since the first proposal, sections anyway. I would like to know a little more about it before we start making amendments that are so vitally important.

There are other proposals as the majority leader knows. Some we are also looking at. I do not think we are trying to stall, and the implication that many of us are filibustering I do not think is correct. We are trying to learn what is in the proposal. I think we are trying to be serious in our deliberations in doing so because we have not had a hearing on this proposal that I am aware of.

Mr. MITCHELL addressed the Chair.

The PRESIDING OFFICER. The majority leader.

Mr. MITCHELL. Mr. President, the Finance Committee and the Labor Committee held more than 50 hearings between them. The Labor Committee completed action on its work more than 2 months ago; the Finance Committee more than 1 month ago. The overwhelming majority of provisions in that bill are drawn from the work of those two committees, which have been well known to most Senators for a very long period of time.

Mr. President, we can stand up here and talk about the length of the bill and how much study is necessary. We have had a survey made of legislation over the past several years, their length and how much time there has been to review them, and it provides some very interesting results which I will not bother to go into now.

The fact of the matter is, we are going to be on this for some time. There has been nothing to preclude Senators from carefully reviewing it. The reality is that we have been prevented from voting on any amendment, on a single amendment, over this period of time, and we believe that it is appropriate that we begin to do so.

I understand the Senator's concern, and I know that he is going to study the measure very carefully and perhaps have some amendments to it. We have been prevented from voting on any amendment and have been prevented from taking any action until now.

That is available to our colleagues under the rules, and there is only limited recourse that a majority leader has under those circumstances. One has been to call for procedural votes. I deliberately refrained from doing so on Saturday because I had not given prior notice of it to Senators, and I try very hard not to take any action without prior notice. I have limited the number of those votes to one today.

I simply want to make clear, so there can be no misunderstanding on anyone's part, if we have not been able to have a vote on an amendment or amendments by tomorrow evening, if we have been prevented from doing so, then the Senate will remain in continuous session; there will be procedural votes at any time without any prior notice so that we can get moving on this bill.

If Senators then wish to speak in an unlimited way, they, obviously, have that right under the rules, and I accept that fact. But we are not going to have a situation where one party uses the rules to the full extent without the other party responding within the rules in the only manner that is available.

So I simply say to my colleagues, we will stay in session this evening for as long as anyone wishes to talk. Perhaps some of the 27 Senators who want to give 4-hour speeches will grace us with them this evening. We will come back at 9:30 tomorrow morning, and if we are still in this situation by tomorrow evening—that is, prevented from voting on any measure—the Senate will remain in session on a continuous basis. And in the event that quorum calls are put in, then procedural votes can occur at any time thereafter without any prior notice.

I yield the floor.

Mr. PACKWOOD addressed the Chair.

The PRESIDING OFFICER. The Senator from Oregon.

Mr. PACKWOOD. Mr. President, let me correct the record first. When I indicated we had, I think I had 27 left, as a matter of fact, to do opening statements at that time, I thought I said 2 or 3 who might want to speak 4 hours. Most have been speaking a half hour, 20 minutes, 45 minutes. My hunch is our opening statements, depending on how we divide up the time—if we did it straight, I would say in a day; if we divide up the time, 2 days, assuming the Democrats fill up an equal amount of time, and they have so far.

But here is the problem we face. This bill does change. The Senate may recall that I asked Senator MITCHELL what had happened to the number of residents and interns and general practitioners, and I was assured it had been dropped out of the bill. I then discovered it has not been dropped out of the bill; it has been changed to a commission, and the commission is directed to find certain numbers of how many people are going to be residents and medical students, even though two Senators assured me it was out of the bill. It was not.

It takes time to find it. Now I have heard—I do not know if it is true—that the 35-percent tax penalty you are assessed if you do not offer the standard benefit plan has been changed to $10,000 per employee. I do not know that. Those are not insignificant changes.

So in fairness, we should have time to do that. I am not going to argue with the leader for a moment on that. We will finish our opening statements in a day or a day and a half, but I hope the leader is not saying that he regard it somehow as an abuse of the rules—I am not going to say it violates them, because he clearly says we are within them—if we come over here and we want to spend a day on the tax titles of that bill and go down the taxes one at a time and say who it is going to affect and here is how it affects them. I hope just for the sake of motion—and that is what I sense it is—the majority leader says we will have procedural votes. That is just what we had. I suggest, a rollcall of absent Members, I say to the majority leader, if that is your idea of motion, Einstein is right.

That is not motion. That is a vote. It does not show us making any progress. Progress maybe is when we have a chance to argue this bill on the merits which is what we have been trying to do. I do not think there has been a speech yet on either side that was not addressing the issue. This was not Huey Long reading the telephone book. They are statements on the bill, which I would hope the leader does not think is an abuse of the rules.

Mr. MITCHELL addressed the Chair.

The PRESIDING OFFICER. The majority leader.

Mr. MITCHELL. I did not use the word "abuse" of the rules. Those are the words of the Senator from Oregon.

Second, I have seen and heard many filibusters in which the Senators talked about the bill. The fact that someone is talking about the bill does not mean that it is not a filibuster or a delay. There is simply no correlation between the two, and it is, in my judgment, wholly illogical to suggest that because someone has been talking about the bill they are not engaging in delay. The suggestion that the only way one can delay is to read the telephone book is, of course, inconsistent with both reality and the past practice of the Senate.

With respect to changes in the bill, the Senator from Oregon has repeatedly attempted to create the impression that that is somehow an unusual circumstance, that somehow there is something wrong or fishy with it.

I look forward to the time when the Senator from Oregon offers his bill as an amendment. I fully expect there will be changes in it, perhaps there will not. We will consider that at the time. But every Member of the Senate knows that legislation changes in process. It is an ordinary event. It occurs with respect to most of the legislation we have here. And that really in my judgment is not a serious argument.

I have described the circumstances as I believe they exist and have attempted to respond to them in a manner that I believe most fair and appropriate under the circumstances. The Senator is the one who has chosen to use other words, and that is his right, of course. I believe that we should proceed in a manner that I have suggested, and to the extent that I have authority to do so, that is the manner in which we will proceed. Senators are free to remain here this evening.

I would note that after I announced last Friday there would be no more votes, although we were told that there were 27 Republican Senators who wanted to make opening statements, only two chose to speak. And that is the point that confirms the point I was making, that there was ample opportunity then. Any 1 of the 27 who wanted to do so could have spoken then for any length of time. Other than two relatively brief statements, none chose to do so.

And so we are simply, I repeat, not going to get into a situation where, under the guise of wanting to make 27 statements of 4 hours each, we are not permitting action to occur on any amendment or any subsequent matter

with respect to this bill and then being unwilling to stay to give those speeches when the Senate is in session and available to permit such speeches to occur.

Therefore, I believe that the decision I have made is the fair and appropriate one under the circumstances and I need not repeat it here.

The Senator from Ohio had asked, and then I will yield to the Senator from Oklahoma following that.

I yield to the Senator from Ohio.

Mr. METZENBAUM. Mr. President, I have been around here about 19 years, and in the 19 years I have been here I have seen filibusters and I have seen majority leaders on the floor of the Senate and with no exception, no disrespect to any of his predecessors, this majority leader has been more patient, more considerate, more concerned that everyone be given a fair opportunity than anybody I have ever seen in that position. And I do not say that disrespectfully of his predecessors. He leans over backward to be fair. He is patient. He is far more patient than any of us would be under the circumstances.

He is well aware of the statements that have been made by the Senator from Texas and other Senators as well that they will do everything possible to keep this bill from becoming law, or an amended version of this bill, who are determined that there be no health care legislation enacted by this session of the Congress.

He has been patient. When an amendment was offered by Senator DODD and many of us were anxious to move forward and vote on it, either vote it up or down, he was patient; he was restrained.

I just want to commend him for saying that he will keep us in session around the clock so that we can move forward on national health care. A filibuster by any other name is a filibuster. When you keep the Senate from moving forward and acting on the legislative process, that is a filibuster. You can say that you need all the time, that 27 speakers need to speak but the fact is you at some time let some legislation move forward, let the legislative process move forward.

But that is not what is happening on the floor of the Senate. It is one delay after another. And this cute idea of how much a bill weighs, well, many of you were here when the tax bill was here, which was much higher than that. You were not worried about what it weighed because you were taking care of some of the special interests who were being provided for in that tax bill.

This is a bill that does not take care of the special interests; it takes care of the interests of all of the American people who want a national health care program. And delaying it, delaying the Senate from moving forward on this legislation is irresponsible. We ought to move forward. If we have the votes, we have them. If we do not have the votes, we ought to lose. But all I hear is talk, talk, talk. And the American people say, "What are they doing there on the floor of the Senate?" They are not doing much.

I say to my colleagues on the other side of the aisle, if you have the votes and you have the amendments, come forward with them. You may win. I read all these different things in the newspapers about this group and that group and all the groups that are making special kinds of deals. If you have something and you have the votes, then vote it up or down and maybe you will prevail.

Let us get on with the business of the Senate, but let us—more importantly than the business of the Senate—move forward to enact or defeat, if that be the will of the Senate, a national health care program. Mr. President, 260 million Americans expect no less of us. What we are doing here is playing games. We are playing political games, games that are not of credit to the Members of the Senate, games that are of no credit to the political system. I think it is high time we get on with the business of the Senate, that we pass a national health care bill or defeat it.

I think the leader is to be commended for saying that we will stay in session. I hope we would stay in session as of tonight. I was prepared to start early. But it is his will—and he is the leader—that we wait until tomorrow night in order to start working overnight. We have worked overnight in the Senate on previous occasions, and it was productive; it really gets a lot of the attention of the Members of this body. They realize what is going on. Under the circumstances now, some do not know what is going on. They just know it is delay and delay and delay.

And so I say, Mr. President, I commend the majority leader. I am proud of him and to be on his team in trying to move forward a national health care bill. I think we have had too much delay already, and I think we ought to get about our business.

Mr. MITCHELL. I thank my colleague.

I yield to the Senator from Oklahoma.

Mr. NICKLES. If the majority leader will yield.

Mr. MITCHELL. May we have order, Mr. President, so the Senator may be heard.

Mr. NICKLES. If the majority leader will yield, we have had the Finance Committee bill, correct me if I am wrong, on the floor of the Senate for 2 weeks.

Let me amend that. We have had the Mitchell No. 1 proposal on the floor for 2 weeks. Is that correct? How long has the original Mitchell proposal been on the floor? I will ask the majority leader, how long have we had the original Mitchell proposal?

Mr. MITCHELL. I stated in my earlier remarks it was produced on Tuesday, August 2. That is my recollection.

Mr. NICKLES. Today is August 15, so it has been 13 days.

We have a list of section changes that were made to the original proposal. I might mention the original proposal was on the floor for some time, and I think I counted 139 section changes, including a change to every title in the bill. Has there been a list of explanations of what the changes were section by section so we would know?

Mr. MITCHELL. I am sorry; I was distracted.

Mr. NICKLES. Has there been a list or an explanation—there are 139 section changes from the original Mitchell proposal. Has that list of changes and an explanation of those changes been submitted so we can look at that without having to try to reread the entire proposal?

Mr. MITCHELL. The section changes are identified.

Mr. NICKLES. If the majority leader will yield, I know the section changes are listed. That is 139, but that does not tell us what change. I have tried to read the first proposal, and I sort of got started in the second proposal, and then was informed by staff last Friday that there was a third proposal which we had, I guess, received Friday evening. I was not aware of it. And I have started trying to study it.

I am trying to figure out if there is a list of changes. The majority leader said they were not significant changes from the second proposal to the third proposal. If we could have a list of those changes, that would help us because some of us—in contrast to my good friend from Ohio—some of us are trying to understand what we have on the floor so we know what we should be considering.

There are some big changes that have taken place between Mitchell 1, Mitchell 2, and Mitchell 3. I think it would help us if we could have an explanation.

Mr. MITCHELL. We will do our best. I want to note that some changes were made at the request of the Republican Senators. I feel it is an irony to be criticized by Republican Senators when we are trying to accommodate other Republican Senators. But I understand it is all part of the process. We will do the best we can to accommodate.

Mr. NICKLES. If the majority leader would yield, I am not being critical. I am trying to find out what is in the legislation. When you get a sheet which says 13 sections are changed, that means a very significant revision. I do not know how many revisions were made in Mitchell 3. But we only had Mitchell 3 on the floor of the Senate Saturday and today. I do not think we

are being dilatory or prolonging the process to try to find out what is in this proposal if it is just laid down on Friday. And to insist on amendments specifically when we do not really know what is in this bill, I think is premature.

Mr. MITCHELL. Mr. President, we have had a lot of theater here in the Senate holding up bills and referring to the length and complexity.

This is a tax reform bill of 1984 when the Republicans were in the majority. The bill is 1,517 pages long, and 52 out of 53 Republicans voted for it. We searched the record, and we cannot find where a single Republican complained about the length and complexity. I am sure that all of those Republican Senators who are complaining about my bill read every word of this bill before they voted on it—[Laughter]—and could answer questions about every single provision in the bill. Let everyone outside this Chamber understand what everyone inside this Chamber knows is going on.

Mr. NICKLES. Would the majority leader yield?

Mr. MITCHELL. Such a long bill as this are common bills. We have had many of them. We have voted on them. The Senator has a perfect right to debate and criticize alternatives to the bill. But let us not go on with this kind of game that somehow the length of the bill or the changes to the bill are what is causing the events here.

Did the Senator vote for this bill?

Mr. NICKLES. I am not sure.

Let me ask the majority leader a question. Was that bill not reported out of the Finance Committee and did we not have more than 48 hours to look at the bill?

Mr. MITCHELL. Let me tell the Senator. He did vote for it.

Did the Senator read this whole bill?

Mr. NICKLES. No.

Let me ask the majority leader.

Mr. MITCHELL. Did the Senator know everything in this bill before he voted on it?

Mr. NICKLES. I doubt that, too.

If the majority leader would answer this question: Was this bill not reported out of committee and available with the committee report? Was that bill not on the desk of Senators for more than 48 hours, more than 24 hours before Senators were asked to vote on it?

Mr. MITCHELL. I do not know how long it was on the floor. But I know one thing. This discussion has gone from providing good information to no information.

I think we have all had—at least I have had all I care to say about the length and weight of the bill, and the changes. And the Senator had asked me to yield for that purpose. Is there anything further he wishes to add with respect to that?

Mr. NICKLES. I did ask the majority leader; I would like a section-by-section analysis or a definition of the changes on these 13 sections. That would help us in our analysis of the bill so we do not have to start all over on this new proposal which we have only had on the floor of the Senate basically for 1 day. If one is available—I would think somebody put these 139 changes together—it would be nice if they would share them with the minority so we may have a chance to analyze those changes as well. They may well be changes for the better. There may be changes and questions from both sides.

I would like to know what is in this bill to some extent, since it has only been on the floor basically for 24 hours, before we start amending.

Mr. MITCHELL. Mr. President, in the Senator's own words, the bill was available on Friday. By any calendar, that is more than 24 hours in the day. It is a small point. But I think it illustrates what is going on in this debate.

Mr. DOMENICI. Might I inquire? I did not get the nature of that bill you were holding. What is that?

Mr. MITCHELL. It says, "That the bill from the House of Representatives (H.R. 4170) entitled 'An Act to provide for tax reform, and for other purposes,' do pass with the following amendments:"

It says "Title I—Tax Reforms Generally," and "* * * may be cited as the 'Deficit Reduction Tax Act of 1984.' "

Mr. DOMENICI. So it is a reconciliation bill, not a freestanding bill like the one we have. It is not subject to amendments, only motions to strike, and debate is limited by operation of law, not by the normal rules of the Senate.

Mr. MITCHELL. Which is an even better argument. I thank the Senator for making my point.

Mr. DOMENICI. That is not a better argument. It means that we have an opportunity here to amend this bill, and debate is open on this bill.

Mr. MITCHELL. Mr. President, I have no desire to hold the floor. I made my statements. Unless any Senator has a further question, I would yield the floor.

Mr. GRAMM. Mr. President, will the Senator yield?

Mr. MITCHELL. Yes.

Mr. GRAMM. I would like to make a couple of points.

Mr. MITCHELL. Senator, I am going to yield the floor.

Mr. MOYNIHAN. Mr. President, will the Senator yield for parliamentary inquiry?

Mr. MITCHELL. Yes.

Mr. MOYNIHAN. Mr. President, is it not the case that Senators must address the Chair?

The PRESIDING OFFICER. That is correct.

Mr. MOYNIHAN. I thank the President.

Mr. MITCHELL. Mr. President, I have said what I intended to say, and I will repeat it now so there can be no possible misunderstanding.

There will be no further votes this evening. The Senate will resume consideration of this measure at 9:30 a.m. tomorrow. The Senate will remain in session this evening for as long as any Senator wishes to speak on the subject.

If by tomorrow evening we continue in a situation where no vote has been permitted to occur on any amendment to the bill, then the Senate will remain in session thereafter, and procedural votes may occur at any time without notice.

I want to repeat that. This is the notice to all Senators, that procedural votes may occur at any time with no further notice beyond the notice now being provided.

I thank my colleagues. I yield the floor.

Several Senators addressed the Chair.

The PRESIDING OFFICER. The Senator from Texas.

Mr. GRAMM. Mr. President, let me make a couple of points.

First of all, we have been operating under a time agreement where each side has controlled half the time. I am not aware of there being a quorum call during this debate. Members have come to the floor, they have spoken on the bill, and they have had an opportunity to tell the American people where they stand on one of the most important issues considered by the Senate in a quarter of a century. We are now in the process of narrowing down the list of Senators who still would like to give their opening statements. Clearly the majority leader has every right to hold us around the clock.

I would like to make two points. First, when the amendments come, they will come in a torrent. I would predict that this week will not end without the distinguished majority leader standing up and trying to stop these amendments rather than inviting more.

Second, let me say that we all understand the rules of the Senate. When the distinguished majority leader opposed cutting the capital gains tax rate, he actually was willing to engage in a real filibuster. We disagreed with him, but we respected him for it, and he killed the capital gains tax rate cut. When the distinguished Senator from Ohio wanted to stop reform of product liability, he killed that bill through debate and through a filibuster. We did not agree with him, but we respected his right.

So here is my point. We are not in a filibuster now, and everybody knows it. We have been operating under an agreement where debate time has been equally divided. We have alternated from side to side, and Senators on both sides of the aisle have made opening statements. I do not see how anybody could call this anything remotely similar to a filibuster.

So simply asking that everybody have a chance to understand the bill and to make an opening statement is not, I believe, unreasonable. But if the Senate Majority Leader wants to hold the Senate in session 24 hours a day, he has a right to do that, and we will all be prepared. The point is that when the amendments come, they will come in a torrent, and they will not stop.

Third, when we have a filibuster—if that is what it takes to stop a government takeover of health care—people will know it, and they will not have to speculate about it. I am hopeful that we can adopt amendments, that we can fix this bill, that we can improve the system, and that we can preserve consumer choice. If we can do that, then I think we can move forward. I do not think we hasten the day we complete the bill by forcing Senators to begin voting on something when demonstrably the vast majority of the Members of the Senate are only now becoming conversant with this bill. I think that is the bottom line.

I think the American people understand that. The point I want to make is that we have been continuously debating this legislation. I do not remember there being quorum calls during this debate. We have an amendment pending, and people have a right to debate it. People have continued their opening statements. Maybe the process will speed up by staying in session 24 hours a day, and maybe it will not. I do not know. But the point is, I do not think anybody can make a reasonable argument that there has been a filibuster. There has been an orderly process, mutually respectful on both sides, where people have made opening statements.

But when people are ready for amendments, be ready. They will come, and they will come in a torrent. I want to make this point, having listened to our dear majority leader—my guess is that by the end of the week, the majority leader will be standing by the same desk with the same smile urging us to stop these amendments.

(Mr. MATHEWS assumed the chair.)

Mr. MITCHELL. Mr. President, I have listened with interest and attention, as I always do, to the Senator from Texas, particularly with his reference to trying to rush on the bill that people had not read. As memory often does, it took me back to my first year in the Senate when the House of Representatives took up a bill that bore the Senator's—and then Representative's—name. I think it was called Gramm–Latta.

I recall reading with interest the stories at the time about how it was slapped together too hurriedly in the House, and that someone had written down his girlfriend's phone number, and that appeared on one of the pages of the bill. It was a Xerox, not a printed copy. Dozens of House Members protested about trying to rush through this massive bill before anyone had a chance to read it, and it was put together in such slap-dash fashion that there were blank pages, blank sections, handwriting, girlfriends' phone numbers, and all other kinds of things.

I just remark with amazement at the Senator's words now about this bill, in the light of that history. But I thank him.

UNANIMOUS-CONSENT AGREEMENT—H.R. 2178

Mr. EXON. Mr. President, I ask unanimous consent that in the engrossment of H.R. 2178, the Hazardous Materials Transportation Act, the Senate amendment be changed to reflect the technical corrections I now send to the desk.

The PRESIDING OFFICER. Is there objection?

Mr. PACKWOOD. Mr. President, if the Chair will hold that a moment, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. EXON. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. EXON. Mr. President, I have made a request as a part of the RECORD. I renew that request at this time.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The amendment is as follows:

In section 119(c)(4) of the amendment of the Senate—

(1) insert "(1)" after "Section 5127(b)", and

(2) insert "(1)" before "There" in the language inserted as new text for section 5127(b) of title 49, United States Code.

In section 211(b) of the amendment of the Senate—

(1) strike paragraph (2) and insert the following:

(2) Section 11501(e) is amended—

(A) by striking all but paragraph (5),

(B) by redesignating paragraph (5) as subsection (e), and

(C) by striking "paragraph" and inserting "subsection".

HEALTH SECURITY ACT

The Senate continued with the consideration of the bill.

Mr. MOYNIHAN. Mr. President, I believe it is the case that there is no time agreement at this point, and the Chair will simply recognize Senators as they seek recognition.

The PRESIDING OFFICER. The Senator is correct.

Mr. MOYNIHAN. I yield the floor.

Mr. PACKWOOD. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. WOFFORD. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Pennsylvania is recognized.

Mr. WOFFORD. Mr. President, I, first, commend the majority leader for his plan that beginning tomorrow, if necessary, we remain in session night and day to get this work done. For the people who do not have health insurance, they do not get to sleep easily at night. The people who are in fear of losing health insurance if they change a job, if they have a preexisting condition, they do not get much sleep at night. I think it is fitting that we not sleep at the switch and that we go ahead, and now that this is within reach that we reach it and get it done.

Mr. President, fortunately, there are Republicans and Democrats who are working together seriously on real health reform, but there are others who want only to block action. They seem to think it will help them politically. They do not put it that way. Instead, they say we must slow down because health care is too big to tackle for this Congress. Instead of acting, they say we ought to study some more. Call it what you want, but as Shakespeare and the Senator from Ohio would say a filibuster by any other name would still smell like gridlock.

Mr. President, we have had six decades of studies, rivers and mountains of studies. We do not need more study about what is wrong with our health care system. We need the backbone to face up to the special interests and take action to protect middle-class families from a health care insurance system which is out of control from those insurance companies who are charging them more and giving them less.

But if they want to study health care, let them study it firsthand, personally and directly what it is like to be a middle-class family caught up in the health insurance mess. Let them study what it is like when your employer cancels your insurance and you have to go out and buy it on the open market. Maybe then we would get action sooner rather than later.

That is why I warned the Senate last week that if the defenders of the status quo succeed in delaying action on health care I will propose an amendment to disqualify every Member of Congress from the Federal Employees Health Plan until we pass a health care bill for the American people. So I am saying support the plan you live under or live under the plan you support.

Americans deserve the same kind of guaranteed coverage and choice of affordable private health plans that Members of Congress have arranged for themselves. Why? Because taxpayers foot the bill for our health coverage

and Members of Congress do not have Government-run health care. They have a range of private health insurance options. They do not have a one-size-fits-all system. They have a consumer-choice system, more choice than most Americans are getting today.

The Mitchell bill will make the Federal Employees Health Plan that Congress enjoys available to other Americans and make it a model for reform. Private health insurance that cannot be taken away. No exclusions for preexisting conditions—you take it from job to job. Affordable premiums paid by a shared contribution from employer and employee. A choice of doctor and health plans.

And what about the Dole bill?

First, unlike the Mitchell bill, the Dole bill will not put us on the path to universal coverage. It does not even pretend to.

Second, unlike the Mitchell bill, the Dole bill is a green light to employers to shift billions of dollars in costs onto the backs of working families.

Third, unlike the Mitchell bill, the Dole bill will not protect millions of people from being denied coverage because of preexisting conditions.

Fourth, unlike the Mitchell bill, the Dole bill will not guarantee that when you leave your job, you can keep your health insurance. It will let the insurance companies keep loopholes that they use to cancel coverage when people change jobs.

Fifth, unlike the Mitchell bill, the Dole bill will not guarantee a choice of doctor and health plan.

And sixth, unlike the Mitchell bill, the Dole bill will prevent most Americans from joining the Federal Employees Plan available to Members of Congress.

Beyond those fatal weaknesses, the Dole bill is especially punishing to older citizens and their families.

Unlike the Mitchell bill, the Dole bill would take billions of dollars in the Medicare program without investing any of this money, these savings, into protecting older Americans.

Unlike the Mitchell bill, the Dole bill has no coverage for prescription drugs.

Unlike the Mitchell bill, the Dole bill has no coverage for long-term care in the home and community.

Unlike the Mitchell bill, the Dole bill will not do anything to change today's absurd system that forces an older person to give up their life savings—and often their dignity—in order to pay for nursing home care and qualify for Medicaid, because it does not include a voluntary, long-term nursing home insurance program.

Unlike the Mitchell bill, the Dole bill will let insurance companies charge older citizens up to four times more than everyone else.

Of course, Americans are skeptical about health reform and about almost everything else we do in this body. After the millions that special interests have spent to mislead and misinform, to spread fear and smear, it is no wonder people are concerned. But they are even more skeptical about those in the insurance industry, not all but far too many, who are blocking this bill and who seem to exist to charge ever higher premiums and cancel coverage just when people need it most.

And they ought to be skeptical of any so-called reform which does not crack down on insurance company practices and policy loopholes that leave middle-class families out in the cold. If the Dole bill is so good, why do so many of those naysaying insurance industry forces like it so much?

Americans want to see a reform that protects above all middle-class families from losing the insurance they have today and a reform that puts us on the road to universal private health insurance coverage.

They want to have the kind of affordable coverage and choice of private health plans that Members of Congress have arranged for themselves. The Mitchell bill does that. The Dole bill does not.

Mr. President, there is hope for a truly bipartisan effort that will go a long way toward real reform. But to those who simply want to protect the status quo, to scare people about change, to use every tactic in the book to bring this reform effort to a grinding halt, I say you are on the wrong side of history.

People are tired of Washington's finger pointing and game playing. They do not want this Congress to squander this chance. They do not want special interests to hijack this reform. And they certainly do not want their health security held hostage to anybody's political agenda.

So on, Mr. President, night and day, let us go on to succeed in winning the battle that Harry Truman started nearly 50 years ago.

I yield the floor, Mr. President.

Mr. DURENBERGER. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. GORTON. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. DURENBERGER. Mr. President, I yield to the Senator from Washington State as much time as he may require.

The PRESIDING OFFICER. The Chair would announce the time is not controlled, so the Senator can be recognized in his own right.

The Senator from Washington is recognized.

Mr. GORTON. Mr. President, the challenge before the Senate is whether we will approve changes that will be positive, acceptable, and affordable to the American people, or, on the other hand, are we going to pursue remedies that serve Big Government political agendas and endanger the very system of care on which we all depend for our families' health?

This debate is historical because it is about nothing less than the role of Government in the most intimate decisions and fearful moments in our lives—the times at which we are in need of urgent medical care to heal ourselves and those we love.

From the outset, this Senator admits to a presumption against Government expansion into areas in which market forces can operate more effectively and cost-efficiently. I am not against Government, but I believe that it should be limited, as the Framers intended, due to its often unaccountable, expensive, arrogant, and sometimes oppressive nature. Consistent with that belief, I am convinced that the Senate should restrain itself from arrogantly approving sweeping measures that will have unpredictable consequences. The Senate should limit itself to those measures we know are likely to improve the financing and delivery of health care. In short, we should fix only that which is broken.

I should like to begin briefly by stating my health care reform objectives and those of the people of Washington State, followed by a discussion of the majority leader's proposal, and then other alternatives to reach appropriate objectives.

I have been on an odyssey of sorts in looking for solutions to the high costs and market distortions of our current health care system. I have sought ways to achieve broad bipartisan reform that truly expresses the diverse concerns of the American people without jeopardizing the quality and choice that makes American medicine the best in the world. In pursuing these goals I have kept the physician's Hippocratic Oath in mind: First we must do no harm.

I have cosponsored proposals ranging from the earlier Chafee plan to the present Dole-Packwood proposal. While I have disagreements with elements of both plans, each includes principles that I believe will bring improvements to our health care system. While there is considerable disagreement over how we get there, there are good reasons that call us to act responsibly.

We need health care reform because the increasing costs of health care threaten to bankrupt both our Government and our families. Too often families facing catastrophic illnesses must first spend down by selling their assets to qualify for public assistance. Due to demographics and unrestrained entitlement spending, health care spending is likely to absorb an increasing proportion of State and national budgets until it makes up 20 percent of the

gross national product within the next decade.

We need reform because too many Americans today do not have health care coverage. Millions of hard-working Americans are without health care insurance and their health expenses are paid for indirectly through a wide range of cost shifting.

Here are my objectives to meet the twin goals of affordability and access to health insurance:

We must allow workers to take their health insurance with them when they switch jobs. Too many Americans are locked in jobs because of a fear of losing good health insurance coverage.

We must protect small businesses from oppressive employer mandates, while we help them provide health insurance for their workers. Our current Tax Code includes absurd disincentives to the self-employed and small businesses that want to insure their employees. We can and should give them the same purchasing power as big corporations and provide meaningful incentives for them to cover their employees.

We must have meaningful medical malpractice reform dedicated to protecting legitimate victims of negligence and our legion of dedicated doctors and other health care professionals rather than providing unlimited business to trial lawyers. The average doctor has a 37-percent chance of being sued at sometime in his or her career. The odds are an incredible 52 percent for a surgeon and an even greater 78 percent for an obstetrician. Defensive medicine, the wasteful procedures performed to protect physicians from lawsuit, cost a good $25 billion in 1991. Meanwhile, the Rand Corp. found that legal costs account for 38 percent of medical liability claims and only 43 cents of every $1 spent on litigation reaches the injured patient. We cannot pretend to tackle waste in our health care system without meaningful medical malpractice reform.

We must promote individual responsibility for the health our people. While our system provides access to the world's finest health care when needed, the obligation to take care of oneself and to avoid preventable illnesses is vital to relieving the current stresses in our health care system. In all the talk of how the Government can help with health care security, we have forgotten the obvious fact that individuals are first and foremost responsible for avoiding their own preventable illnesses.

Similarly, we must promote preventive care so that our current system, which focuses on healing the ills, will save money by preventing illness in the first place. We must support biomedical research and the innovations in biotechnology that are an important basis for preventive care as well as for dealing ever more effectively with serious illnesses and disabilities.

We must insure quality and choice for families when they make their health care decisions. From every corner of the Earth, people come to the United States for the very best medicine and care the world has ever known. They come to train in our medical schools that provide the best education and residency programs. They come for miracles that occur on a daily basis, and must not be taken for granted.

Most important, we must acknowledge that increased coverage will cost money. To some that may be stating the obvious. To this Senator, the obvious deserves equal time in this debate.

Similarly, we must acknowledge that our health care system provides millions of good jobs for individuals who have dedicated their lives to the health of others. We cannot ignore the impact on these jobs that some health care reform proposals will have.

In addition, we must acknowledge the reality that our system of financing and delivering health care is radically changing as we slowly contemplate our own perhaps less proposed relevant changes. This Senator is convinced that by the time a national health care reform program is enacted, we will need to alter it just to keep up with a much more responsive and efficient marketplace.

Just look at health care inflation. While inflation was among the primary reasons for demanding the reform of our health care system less than a year ago, it is now hardly mentioned because health inflation is at its lowest point in 20 years. Some inside the beltway assert that it is only the threat of Government action that has restrained health care spending. While the threat of Government-run medicine has caused some health care stocks to plummet, it is primarily employers tightening their belt, negotiating with insurers, and eliminating waste that has slowed the increase in health care spending. Again, the marketplace has responded to inefficiencies and high costs much more quickly than the Government could imagine.

A major source of innovation and efficiency in the marketplace is the right of companies to self-insure. Self-insurance is possible only because of the Employee Retirement Income Security Act, or ERISA, which gives self-insured employers the flexibility to negotiate plan design without the expensive and explosive mandated benefits required by State governments. As my senior colleague from Minnesota so eloquently has informed us, ERISA has provided a national uniform rule that permits true competition in the health insurance marketplace to occur. Self-insurance and ERISA are not broken and therefore need not be fixed in health care reform.

Another example of market ingenuity that must be preserved and promoted in health care reform are medical savings accounts or medical IRAs. Under this option, employers establish an account for their employees to which they contribute monthly amounts for employees to spend on medical costs or premiums for health plans of the employees', not the employers' choosing. This promotes consumer awareness, value, and responsibility while guaranteeing flexibility and lower administrative costs for the employer.

Here is what we must avoid: Government run medicine that turns decisions between a physician and his or her patient over to Government bureaucrats rationing care under a global budget. The more obstacles you put in the way of a decision by a physician to determine the most appropriate care for his or her patient and the application of that care, the more you jeopardize the quality and add to the costs of the health care received. That is simply the reality of centralized medicine illustrated by literally thousands of Canadians who come south each week to the United States to pay out of their own pockets for health care when and how they want it. The fundamental goal for reform must be market-based or it will not have my support or the support of the American people.

Most important, we must not punish those States that have moved forward with health care reform, that have imposed new taxes, new regulations, new bureaucracies, and new mandates. My State of Washington has enacted a comprehensive plan for which the details are still being worked out. Enormous change is underway that may be positive or negative depending on the substance and timing of Federal and State action. Careful consideration must be given to these States so that ultimately their citizens do not pay twice for health care reform.

My goals are ambitious and my concerns are many. They are the product of an extensive listening process to the people of Washington State for the last 3 years. People, who, like the rest of the Nation want positive, affordable, and acceptable changes in our health care system. They, too, are skeptical that the current proposal by the majority leader will meet those goals and address those concerns.

My first impression of the 1,400-plus page Mitchell health care proposal reminded me of Mark Twain's description of how Tom Sawyer felt when he first approached that "thirty yards of board fence nine feet high."

Now, we all know how Tom finished the job. He convinced everyone who stopped by that this was the finest chore imaginable, almost a historic opportunity. Sooner or later, all the neighborhood kids were swapping their treasures just so they could have at that fence.

The Senate has before us in the Mitchell bill an enormous board fence.

The question is, in this case, do we have to whitewash the fence, or do we need to construct another fence altogether? After examining the costs, new bureaucracies, mandates, taxes, malpractice provisions, and regulations in this proposal, this Senator is convinced that reconstruction, not whitewash, is the only practical solution. This proposal is simply not affordable, constructive, or acceptable to the American people.

The Congressional Budget Office, the umpire given the dubious task of judging the economic impact of the majority leader's health care plan, recently came to the same conclusion. It found that between 1997 and 2004, the subsidy program to cover 26 million people in the Mitchell bill would exceed $1 trillion. The annual cost of this premium assistance would average $100 billion annually, or approximately $3,850 per person currently without insurance. In only its second year of operation, this new entitlement program would be the third largest Federal expenditure behind Social Security and Medicare.

Assuming that these projections are correct is itself a risky venture. Keep in mind that actual costs for Medicare spending in 1962 were 10 times higher than estimated. In any case, such an announcement came during the same week in which the Bipartisan Commission on Entitlement and Tax Reform announced its dire predictions of the future under our present spending habits, including the following:

> In 2012, unless appropriate policy changes are made in the interim, projected outlays for entitlements and interest on the national debt will consume all tax revenues collected by the Federal government.

Of course, that did not include any of the new entitlements in this bill.

Yes, expanded coverage through subsidies will be expensive, but an even more important question is whether we would get our money's worth and a guarantee that this is not just another major expansion of government? We need to help make health insurance affordable to those in need, but another open-ended entitlement program is clearly not what the country needs or can afford. Difficult choices lie ahead, but the option of having the American taxpayer forking over more hard-earned pay is not an appropriate one. Everywhere but on Capitol Hill it is obvious that this option is not affordable. We can do better. CBO's analysis of the tax increases called for in the Mitchell plan raises serious doubts as to the plans level of acceptability to the American taxpayer. Of particular concern is the 25-percent excise tax on high-growth premiums. CBO found that the tax:

> * * * would be difficult to implement. In addition, its contribution to containing health care costs would be limited, and it might be considered inequitable and an impediment to expanding coverage.

What CBO has found is simply common sense. Those plans which currently are efficient and carry low costs will be penalized significantly more than those plans that are wasteful and expensive. In an effort to protect constituencies with Cadillac health care plans and to avoid a blatant tax cap, the majority leader suggests we punish those who have succeeded in keeping their costs low. CBO concludes:

> Such an assessment would increase premiums, and higher premiums would discourage participation in the voluntary period.

In other words, we may pay more and get neither cost control nor expanded coverage. That is not acceptable to the American people. These are tax increases which I believe to be unnecessary. And any tax increases certainly should have to be justified by achieving their intended ends.

We have often heard proponents of employer mandates make the following argument: Since our current health care financing system is employer-based, why not take it one step further and demand that all employers pay for health insurance and then give it a nice term like "shared responsibility." They neglect the obvious and vital fact that employers offer voluntary employer-based system insurance to attract and keep employees. That is like ignoring the difference between a draft and a volunteer army. It is not subtle; it goes to the very difference between market forces and Government mandates.

The results of our voluntary system have been impressive. In 1992, employers spent $252 billion for health benefits. Outlays for all health benefits have increased as a proportion of total compensation from 1 percent in 1960 to 7 percent in 1992. Even so, that is not good enough for advocates of employer mandates.

The goal of universal coverage in the majority leader's proposal rests on the false security of an employer mandate that would kick in 8 years from now and cover not only employees but their dependents as well. Although the mandate is claimed to be conditional on less than 95 percent coverage, it is actually inevitable due to another mandate: the one-size-fit-all benefits package. By forcing conformity to essentially one product, those employers who could not afford that product would simply opt out—increasing the number of uninsured.

The employer mandate does not affect the employer as one might imagine—it will be the employee who suffers. Even CBO agrees that:

> Economic theory and empirical research both imply that most of this increased cost would be passed back to workers over time in the form of lower take-home wages.

Moreover, the employee mandated share—50 percent—would amount to new payroll tax of up to 8 percent. How the individual mandate is enforced or monitored by the employer is a question the majority leader does not answer.

One needs to look no further than my own State of Washington to see the impact that employer mandates and mandated benefits packages will have on the job force. There small businessmen and women are preparing for an estimated 70,000 lost jobs by the time the State health care reform is fully implemented in 1999. While proponents espouse subsidies as a relief for small business, the reality is that most entrepreneurs do not care for assistance, do not believe that the funds will be there, and would rather go broke before taking their own tax money from the Government.

We must improve our current voluntary system by establishing purchasing cooperatives to ease the administrative and financial strain of finding health coverage for employees. Small businesses should have the same tax incentives to purchase health insurance as large corporations and be allowed to organize to their similar purchasing power. While some may argue that an employer mandate is a simple small step to universal coverage, this Senator simply does not accept the idea that we must trade jobs for health care reform.

While the new taxes, mandates, and costs of the Mitchell plan render it neither affordable or acceptable to the American people, it is the exceptionally large new role of Government bureaucracies weaved throughout the entire measure that alarm me the most. In its report, CBO acknowledges that:

> For the proposed system to function effectively, new data would have to be collected, new procedures and administrative mechanisms developed, and new institutions and administrative mechanisms developed, and new institutions and administrative capabilities created.

While the majority leader claims that this bill is based on a private system of delivery, his proposal creates no fewer than 50 new bureaucracies, including a National Health Benefit Board, State Risk Adjustment Organizations, Health Plan Service Areas, Prescription Drug Payment Review Commission, National Council on Graduate Medical Education, National Advisory Board on Health Care Workforce Development, Healthy Students-Healthy Schools Interagency Task Force, United States-Mexico Boarder Health Commission, Health Information Advisory Committee, Mandatory State-based Alternative Dispute Resolution, Compliant Review Offices per each area, and the National Health Care Cost and Coverage Commission, just to name a few.

Only after reviewing the duties and obligations of these new offices can one truly begin to understand the scope of radical change and expansion in the Government's role in health care we are contemplating. Some advocates of Government-run medicine believe that if you just "build it they will come"—

that somehow if you build an infrastructure of bureaucracies you can address all the needs of the people more efficiently than they can themselves. This Field of Dreams, however, is clearly a nightmare that should never be built.

CBO concludes with the following understatement:

> There is a significant chance that the substantial changes required by his proposal—and by other systematic reform proposals—could not be achieved as assumed.

In other words, these enormous and expensive changes may not prove positive.

As I have noted, this Senator is not anti-Government—I simply believe that Government must be limited and that empowered individuals can usher in positive change more readily than mandates and big Government. I subscribe to the theory Jefferson expressed when he wrote:

> I know no safe depository of the ultimate powers of society but the people themselves; and if we think them not enlightened enough to exercise their control with a wholesome discretion, the remedy is not to take it from them, but to inform their discretion.

We can address the shortfalls of our current system without creating an unprecedented growth in Government to control more and more elements of our health care decisions.

As I stated earlier, meaningful reforms in our medical malpractice system are a prerequisite for my support of any plan. The current medical malpractice system serves neither legitimate claimants or defendants well and is a source of unnecessary expense and waste in the health care industry. Only 43 cents of every dollar spent in medical malpractice litigation reaches injured patients, while the price of defensive medicine may well add as much as $25 billion to our national health care spending every year. Comprehensive medical malpractice reform could save as much as $35 billion over the next 5 years by curbing premium cost increases and many defensive medical practices.

The rear of frivolous malpractice cases and real increases in malpractice insurance premiums is taking a toll. The Institute of Medicine concluded in 1989 that the traditional tort system is a slow and costly method of resolving obstetrical disputes and that it contributes to the disruption of the delivery of obstetrical care in this Nation, especially in rural areas. Almost one out of eight obstetrician/gynecologists has dropped obstetrical practice as a result of liability risks. One study found that increasing liability costs and threats have led 70 percent of physicians to order more consultation, 66 percent to order more diagnostic tests, 54 percent to order more follow-up visits, and 28 percent to perform procedures they ordinarily would have delegated to other medical personnel. For health care providers, a frivolous or meritless malpractice claim can lead to personal and professional ruin.

Considering that the Washington Post reported by last April 20 that the majority leader was inclined against including medical malpractice reform in health care reform, I was pleased to see a section dedicated to it in his proposal. Unfortunately, after I reviewed the sections—providing open-ended litigation, and an entire new source of remedies—I concluded that these provisions alone would be reason to oppose the entire measure.

Instead of limiting the waste that zealous attorneys bring to our health care system, the Mitchell plan offers endless opportunities for trial lawyers to seek more causes of action and deeper pockets. He proposes State-mandated alternative dispute resolution mechanisms that have not been proven to save significant ligation costs, but do keep lawyers employed. He proposes certificates of merit that unfortunately are as easy to produce as an expert witness. He allows for periodic payments and studies on medical negligence, medical guidelines, and enterprise liability. Finally, the majority leader proposes limitations on attorney's fees at a level which regrettably only reflect the status quo.

But an entire new section on remedies for claims disputes will bring a smile to every medical malpractice plaintiffs' lawyer in America. Under the majority leader's plan an entire new source and process for remedies is mandated on the States. Section 5502 dictates that each State:

> shall establish and maintain a complaint review office for each community rating area established by such State.

Throughout the remedies sections, the Mitchell bill ignores attempts to deter frivolous cases by providing for "reasonable attorney's fees, reasonable expert witness fees, and other reasonable costs relating to such action." Section 5505 provides new civil money penalties available from the Department of Labor.

On top of all that, complete judicial review in a court of law is available, as well as private rights of action, in case the responsible bureaucracies do not pursue certain claims. Essential community providers are provided civil and administrative causes of action for "failure of a health plan to fulfill a duty imposed on the plan."

In a bizarre attempt to blur the doctrine of separation of powers and preempt a court's discretionary powers, section 5540 provides that the U.S. District Court for the District of Columbia, which has original jurisdiction over constitutional challenges to the measure,

> may not grant any temporary order or preliminary injunction restraining the enforcement, operation, or execution of this Act or any provision of this Act.

In addition to these measures, the Mitchell provisions relating to discrimination include some unprecedented litigation opportunities that may render the entire health care system unworkable. It is worth restating the entire section. Section 1602 provides that:

> The Secretary of Health and Human Services, and any State, health plan, purchasing cooperative, employer, health program or activity receiving Federal financial assistance, or other entity subject to this Act, shall not directly or through contractual arrangements—
>
> (1) deny or limit access to or the availability of health care services, or otherwise discriminate in connection with the provision of health care services; or (2) limit, segregate, or classify an individual in any way which would deprive or tend to deprive such individual of health care services, or otherwise adversely affect his or her access to health care services; on the basis of race, national origin, sex, religion, language, income, age, sexual orientation, disability, health status, or anticipated need for health services.

The section provides further that the section will apply, but is not limited to, the determination of the scope of services provided by a health care plan, and the provision of such services and determination of the site or location of health care facilities.

This section would have two predictable effects that undermine the entire delivery of health care and many unpredictable ones that will be litigated endlessly. First, a provider would always be vulnerable to a lawsuit if it chose to deny care that it felt was inappropriate or decided on a course of treatment that was not preferred by the patient. The result is the formation of an even more costly health care system based entirely on defensive medicine.

Second, for the first time, discrimination based on health status, anticipated need for health services, language, income, and sexual orientation would be actionable grounds for Federal civil rights claims.

Instead, we should pursue caps on noneconomic damages at $250,000, several liability for noneconomic and punitive damages, periodic payments, the collateral sources rule, limits on contingent attorneys fees, statutes of limitation, and effective consumer protection. Instead of weakening the relationship between doctor and patient by encouraging malpractice claims, we should strengthen the relationship. Instead of leaving injured patients at the mercy of attorneys and the courts, we should provide mechanisms for quick and fair relief.

The medical malpractice reform provision in the Mitchell bill provide clear examples of why the American people want us to proceed with caution in health care reform. They will make changes for the worse, cost more, and cripple a legal system already under strain from too much litigation.

My greatest concern is that the Mitchell plan will leave the people of the State of Washington paying twice for health care reform either through the new taxes, mandates, regulations, or additional layers of bureaucracy. Of particular concern is the tax on growing health care premiums that punish States like Washington which now have lower health care costs than average that will inevitably rise under community rating. The 1.75-percent tax on all plans does not spare Washingtonians who have already paid taxes for health care reform. As our State plan is implemented, this Senator will insist that the cumulative Federal and State changes ultimately provide changes that are positive, acceptable, and affordable to the people of Washington State and do not charge them twice for the same services.

Regrettably, all the whitewash in the world will not cover up the taxes, mandates, and bureaucracies. We need to build a different fence. Fortunately, there are other fences from which to choose.

In the next 10 days, my colleagues from New Mexico, Georgia, and elsewhere intend to introduce a Bipartisan Health Care Reform Act similar to the Rowland-Bilirakis measure in the House of Representatives. Unlike other proposals, the American people can at the very least trust its title.

This market-based, voluntary proposal builds on wide areas of agreement among members both Liberal and Conservative, Democrat and Republican. It focuses primarily on that which is broken in our health care system.

Specifically, it includes health insurance reforms so that employees won't lose coverage when they switch jobs. It limits preexisting condition exclusions and provides additional safeguards against harmful insurance practices. Employers would be required to provide, but not pay for, at least two options—a standard coverage and one high-deductible plan. Medical savings accounts would also be an option.

Small employers would be enabled to gain the same purchasing power as large corporations for the purpose of purchasing affordable health insurance for their employees. Medical malpractice reform, clarification in antitrust laws, fraud and abuse control, and administrative simplification aim to lower wasteful health care spending. The cost of the plan is estimated to be approximately $140 billion over 5 years, a fraction of the majority leader's proposal. Savings in Medicare and Medicaid are intended to make the plan budget neutral.

Quality and choice are preserved under this measure. Employers will not lay off employees due to coercive mandates. It does not trade jobs for health care. It helps those in need get assistance through limited subsidies. The entire spending side of the proposal is subject to a fail-safe mechanism that ensures an affordable outcome. This is a bare-bones, market approach for the 1990's—not a big government, taxpayer financed boondoggle of the 1960's.

Will it solve all the problems in our health care system overnight? Probably not. It does not pretend to. Is it revolutionary or radical? No. It builds on the successes of American medicine. It recognizes that market forces in the health care industry are moving more rapidly than we can respond. It recognizes that open-ended entitlements and employer mandates are not the legacy we want to leave our children.

I am anxious to see the cost estimates for this proposal from the Congressional Budget Office. Meanwhile, my impression is that it is the kind of health care reform that the American people will find to be positive, acceptable, and affordable. In fact, this proposal seems to build on the Better Access to Affordable Health Care Act of 1991 introduced by then-Senator Bentsen and Representative DAN ROSTENKOWSKI, which I cosponsored in the Senate.

The sponsors of the Bipartisan Health Care Reform Act truly reflect the concerns of the American people. They are fiscal conservatives devoted to improving the health security of American families. I trust their motives, commend their dedication for positive changes in health care, and look forward to hearing their arguments.

While advocates of more radical health care reform have called for immediate and revolutionary changes in our health care system, this Senator advises his colleagues to take a different course. Now is not the time for hurried consideration or blind faith in complex redesigns of something as important as our health care system. Now is the time for humility, not hubris.

As Adam Smith wrote in the Wealth of Nations:

> It is the highest impertinence and presumption, therefore, in kings and ministers to pretend to watch over the economy of private people, and to restrain their expense. They are themselves always, and without exception, the greatest spendthrifts in the society. Let them look well after the own expense, and they may safely trust private people with theirs.

Now is the time to trust the American people, who are making it overwhelmingly clear that radical exchange in their health care system is not their desire. The cameras are on and they cannot be fooled. They know that "shared responsibility" means mandates. They know "contribution" means "tax." They know that a product of a conference committee that rejects the consensus of a Chamber should be rejected. More than ever, and some for the first time, are watching because they are rightly concerned that we will do the very harm they want us most desperately to avoid.

Mr. President, I urge my colleagues once again to heed the words of my constituents for whom the future impact of some types of health care reform is happening now. Kim Ward, a small business owner in Kirkland, WA, offers the following advice:

> If there is one thing that I could pass along to the Senate it would be—take your time. It is important that the things Washington State is currently doing * * * be done prior to passing any law. If Washington State had talked openly about health care, its effect on business and their employees, the outcome may have been different than the law passed. Currently, everyone is trying to figure out how to fix the current law.

Mr. President, you and I both know that you can not fix comprehensive health care reform once it passes and impacts one-seventh of the Nation's economy. We have only one opportunity to do health care reform, and we must do it right or not at all. Right is more important than fast.

Mr. President, most of this I wrote or thought about before the remarks by the majority leader early this evening. Those remarks and my own I think are even more relevant at this point. This Senator is absolutely convinced that the proposal before us, all 1,400 pages, can only be passed if the people of the United States do not know what is included in it. They do not want the radical changes and governmentalization of this proposal. They want it and its alternatives thoroughly discussed. They want it discussed in the light of day, not in the middle of the night. They want to be able to have an influence over the major elements in that debate on amendments, on proposed changes, on total and complete substitutes.

Overwhelmingly, their advice to us is to make certain that we get it right the first time, not to pass something that we do not understand and they do not understand. If it takes another year to do it right, the American people want us to take another year. If we can take some steps forward now, if we can do some things to improve our health care system, they wish us to do it. But they do not wish the Senate of the United States, which alone of the bodies of our Government has the power, the authority, the right, and the duty to deliberate carefully, to pass this bill by the end of this week or the end of next week before the American people understand it at all. They want us to do this job right, and it is far more important to do it right than to do it fast.

Mr. DURENBERGER addressed the Chair.

The PRESIDING OFFICER (Mr. ROBB). The Senator from Minnesota is recognized.

Mr. DURENBERGER. Mr. President, before I yield the floor to the Senator from Texas, may I make an observation as follows? Other than as a very small child when my grandfather

worked for the then Great Northern Railroad and used to take me on trips to the great Pacific Northwest, I think about 1984 was the very first time that I returned to Washington State. I was there at the invitation of the then junior Senator who just finished speaking. I was there to talk about health care, and I was there to listen on the issue of health care because he was persistent that I do. I was impressed by the time and quality of the people in the State of Washington to health care and health care reform, and especially the quality of the commitment of the Senator who has just finished speaking.

I have not yet in this debate heard an explanation of what is at stake in health care reform that has been quite as complete, quite as thorough, and quite as on the point than the one we just heard.

I have welcomed the work of our colleague from Washington in everything that we have done in health care reform. And as he has pointed out, he has been in the middle of the debate in an ideological or philosophical sense. He participated with us though the mainstream having worked with Senator DOLE on his bill and now having expressed an interest in the similarities all of these bills have to what is in the House bill. I think out of that should come a message not only to the people of America but to the people of this Chamber as to where the consensus lies if we are to do health care reform this year.

I would suggest that the majority leader, and others in a position to do so, could do worse than open up the CONGRESSIONAL RECORD tomorrow morning and read the statement by our colleague from Washington State, and take his advice. He has been sent here by the people of that State because they are trying to do reform in the State of Washington. I think they passed legislation, as he pointed out. But they, as the people in Minnesota, recognize that you cannot do this a State at a time. We need a set of national rules by which health care markets can work. As he has already pointed out, it is impossible to believe that we need this much ruling from the National Government.

Mr. GORTON addressed the Chair.

The PRESIDING OFFICER. The Senator from Washington.

Mr. GORTON. Mr. President, I thank my dear friend and colleague from Minnesota for those kind remarks.

As he knows, I have relied very greatly on him for advice during the course of not just this debate this year, but, as he knows, for the last 2, or 3, or 4 years during which we have tried to work on this issue. I suspect he shares the view that every time we work out a conflict and we have correctly answered one question, we find two or three other questions popping up. And the more we learn about this issue the more humility we have about it, and the more we want to make sure that we are absolutely right with every step that we take forward because we are dealing with perhaps the most profound of the concerns of each of our constituents.

Mr. DURENBERGER. Mr. President, I yield such time as she may require to the Senator from Texas.

The PRESIDING OFFICER. The Senator from Texas is recognized.

Mrs. HUTCHISON. Thank you, Mr. President.

Mr. President, the health care industry constitutes one-seventh of our Nation's economy. That cold fraction represents millions of jobs, and the livelihood of millions of families in our country. But even more sweeping is that every American's quality of life is at stake in this debate. The excellence and availability of health care determines the quality of American life.

I have heard so many moving stories of people struggling with illness, and I want to mention some of them. A Florida man employed seven people in his furniture store. Over the last few years his health care premiums have increased dramatically. Last year, he learned that he could no longer insure all of his workers because two of his employees had become high risk due to their older age.

A nurse here in Washington said that when a little boy asked her to sit with him during a chemotherapy session she had to leave that little boy alone to go to a mandatory class on how to fill out a form that had no direct bearing on the health of the children she was treating.

An elderly couple in New Hampshire had to sell food out of their refrigerator to pay for their medicine. Another woman had to quit her job and go on public assistance in order to afford expensive treatment for her sick son.

Another couple had a sick child, and their only source of insurance was one of their parent's employers, forcing the employer to either let that employee go or raise the insurance premiums on all 20 of that firm's employees by $200.

Do these stories sound familiar? They are all true, and they are all tragic. And they have all been told by the President of the United States in an attempt to incite a revolution that would cause a radical change in American life. These stories are a legitimate cause of action. They call for responsible actions, not impetuous experimental upheaval.

These sad stories should not be used to argue that a good but imperfect system should be destroyed. They should be used as an incentive to perfect the system.

Let me put this in perspective. Eighty-five percent of the American people have health care coverage, and most are happy with it. Of those who are uninsured, almost half will be covered within four months, and every plan introduced in this Congress would allow them to have continuous coverage. President Clinton, Senator MITCHELL, and Congressman Gephardt are asking the question, how can we bring the other seven or eight percent into the system? I think the better question would be how can we bring the other 7 or 8 percent into the system without harming the quality for the 85 percent now covered?

These are two very different questions, and they produce very different answers, as you can see, when you compare the Mitchell plan to the Dole plan.

The Clinton, Mitchell, and Gephardt plans have all a universal feature. They put universal coverage above everything, including quality of care. What will our universal coverage buy us under these systems? Is it the Canadian system, the system where you must wait 6 months for a heart bypass operation, 9 months for cataract surgery, 3 months for a mammogram?

What about the woman who wrote of her experience having a baby in Canada? There was only one anesthetist in the hospital. Since there was an emergency surgery in progress, when she went into labor he was not available. By the time the emergency surgery was over, it was too late to help the woman having the baby.

In America, any woman, regardless of coverage, can have anesthesia if she wants it when she is having a baby. That is because we have the best quality available.

I experienced this firsthand when I was a volunteer, a Red Cross nurse's aid, at Ben Taub Hospital in Houston, TX. Ben Taub was the charity hospital. I worked in the labor room taking their blood pressure, holding their hands, trying to make the women in labor more comfortable before they received anesthesia and went into delivery. The care they got was excellent. And it made me proud that in America everyone would be treated so well.

Mr. President, supporters of the Clinton-Mitchell plan say they want universal coverage. That is a noble goal and one that I share. But let us look at the method for achieving that goal.

The most important feature is mandates—employer and individual. What is wrong with mandates? Well, for one thing, they do not work. The Government of Canada mandated universal coverage, but Canadians do not have it. The government of Hawaii mandated universal coverage, but Hawaiians do not have it. Now the Government of the United States is debating a mandate and even its biggest proponent, President Clinton, admitted recently that it will not provide universal coverage here either. So why would we tear down our system for a goal of universal coverage when we know it cannot be achieved?

The President talked about employer mandates, to make everyone who is not

an employer feel safe under the Clinton-Mitchell plan. But no one would be safe. An employer mandate is really a tax on employees. Many small business owners have told me that it will affect what they can pay in wages. The legacy of the Clinton-Mitchell plans would be more unemployment, less income, and less output.

The American people know what is best for their own families. If we make health care coverage accessible, affordable, and portable, those who have coverage now can keep it, and more will be able to come into the system and buy it. The American people are sick and tired of having decisions made for them by the Federal Government.

The individual mandates in this bill are onerous because the individual will be required to either contribute to an employer-offered standard benefit package, or individually purchase and fully pay for that standard package. The choice of what is best for you and your family will be taken away by this Government mandate.

Why are the Clinton-Mitchell bills so unresponsive to our Nation's needs? I think the answer is that the administration has failed to target the problem in our system. A faulty diagnosis leads to a harmful cure. So what are the real problems? I believe the major one is underinsurance. Eight to 15 percent of Americans have no insurance. Many have partial insurance that excludes serious, often expensive, major ailments. Both of these groups face severe financial costs if their conditions get worse. That is the major problem: not enough insurance.

There are other problems in our system: a malpractice explosion, too little prenatal and preventive care, and doctors and hospitals that are too far removed from rural Americans. We will be discussing these and others over the next couple of weeks, and I will support bills and amendments to address these problems. But the simple problem is access to care and access to insurance.

Before we rush to recommend a cure, we should examine the healthy parts of our system and make sure we protect those healthy parts. The Hippocratic oath that doctors have taken for centuries says, "primum, non nocere: first do no harm." So we need to look to our strengths and make sure to protect them.

In spite of its flaws, our hope is to improve the system. The United States does have the greatest health care system in the world and the finest doctors in history. We have the most advanced medical technology, the best drugs, the most intense research, and the best medical training. People from every other nation on Earth come to America for serious medical treatment because they know it is the best.

Our colleague from Georgia, Senator PAUL COVERDELL captured this truth a few months ago when he said, "If you are a cancer survivor, it is because, by the grace of God, you live in the United States of America."

Many of our colleagues have related experiences with constituents during this debate and I had one, too, that illustrates this point. I was at a town hall meeting in Irving, TX, and a beautiful, poised young woman, who was the picture of health, revealed that she had just survived a colostomy, another grave ailment, and she must wear equipment 24 hours a day for the rest of her life. None of this was apparent. She looked like any other person in the room, except that she was drop-dead gorgeous. I asked her to come to the front of the room so everybody could look at her as a walking symbol of the health care system in America.

Good quality also requires competition. That is the secret of our economy and why we are the strongest Nation on Earth. That is why we have been able to develop the best health care system in the world. Competition works throughout the system. Students compete to get into medical school, and the brightest are the only ones that get in. Medical schools compete for those students, and the results of this competition is outstanding medical training. Doctors compete for patients, hospitals, and HMO's compete for doctors, and again the system rewards quality.

This is not the first time that a nation built on competition has seen one segment of its society try to abolish competition. But it may be the most dangerous.

Why do you think most companies now offer health insurance? It is not because of a government mandate. Companies compete for workers. They offer health insurance because it is a good way to attract them. If it is customary for many Americans to purchase health care through their employers, it is not surprising that you will find that many uninsured people are among the unemployed. The latest estimates tell us that 58 million people are uninsured for an average of less than one month in a year. Half of all uninsured spells last less than 6 months, and three quarters last for less than a year. So among the chronically uninsured are those who do not file income taxes and do not have mailing addresses. We all know that if they walk into an emergency room, they will get care. But as for insurance, no version of the Clinton bill will cover them, and everyone knows it.

I represent a State that is largely rural. My constituents and their farms and ranches in the small towns across Texas are concerned that they have access to regular care without the burden of traveling to one of our large cities. The Mitchell bill has some good provisions aimed at helping rural Americans. But it also needs other parts to be added to really help rural America. The Mitchell bill lacks complete deductibility of insurance premiums for self-employed citizens. It lacks medical savings accounts which would help everyone, but especially those in rural areas. It hurts rural small businesses by outlawing their self-insurance. It would punish good insurance plans that seek to expand into rural areas.

The Mitchell bill also contains massive new taxes. There is a 1.75-percent tax on every American health insurance plan. The Mitchell bill levies a 25-percent excise tax on high-growth plans.

If you had any doubt about claims that the Mitchell bill would harm quality, lay them aside. It taxes quality. If the cost or value of a benefit plan exceeds the target growth rate, that plan will be taxed. So if you go beyond the Federal cookie-cutter benefit plan, a confiscatory 25-percent tax is levied. Studies show that taxing benefits does not control health care costs. It simply shifts more of the Nation's health care bill onto the middle class—the middle class. They seem to get it every time.

Benefits have always been designed to attract employees. But the Mitchell bill says loudly to employers: Do not be generous with your employees or the Government will punish you. This is a step backward from health reform.

Let us look at some projections about Clinton-style health care in the future. Last winter a staff report from the Joint Economic Committee projected that, in addition to the new taxes it would need now, it would run out of money so fast that Congress would face the following choices by the year 2000: Increase the deficit by $426 billion, or a $3,500 tax on every family in America, or a 15-percent payroll tax on every business in America, or rationed health care.

None of us wants to face that kind of choice, and we can stop that choice from happening today and this week and when we pass the bills that we are taking up right now and will be debating for the next few weeks.

If you look at the taxes and mandates in this bill together, you will see the full burden of the Clinton-Mitchell health care plans on business. The Heritage Foundation found that in the first year of mandates, Texas companies alone would pay an additional $5.6 billion.

I want to read a few letters from some small business people that wrote me about their concerns.

Danco is a small air-conditioning and refrigeration business in Waco, TX, employing six people. Kim Obenoskey says:

> We have been in business for 10 years. Presently our third largest expenditure following only the direct cost of labor and materials is the cost of insurance. We do not offer health insurance coverage to our employees because it is an expensive cost that has escalated at unpredictable rates.
>
> What we do not need is mandates on employers. We spend enormous amounts of

money on government regulations at present. This is money we could and would be compensating our employees with.

I do hope that Congress can see straight enough to know that there ought to be a guide not a dictator. The human race is not yet completely incapable of getting out of bed in the morning without government to tell us which side is best suited to our needs.

CPI Systems in Houston, TX, R. Bailey—no relation—writes to me:

As a small business owner, I do not want the federal government to control or participate in any health care program. Any program or re-vamp of the existing health care system needs a deliberate view of all existing benefits. Not just any cobbled up program to meet a calendar deadline.

From S & S Enterprises in Hughes Springs, TX:

DEAR SENATOR: Regarding President Clinton's plan for health care reform: I am convinced, as the owner of a small business, that enactment of such legislation would seriously cripple, if not kill, the operation of my business, thus eliminating employment for myself and my ten (10) employees.

I hope these figures and these letters put the problem into perspective, and by perspective I do not mean ignoring part of them. I share the goal of making insurance accessible to everyone. But there is a bill that will give access without harming our economy or our liberty, and that is the bill offered by the Republican leader.

Mr. President, the Dole-Packwood bill will make insurance portable from one job to another. People would no longer need to fear changing jobs or losing their job since they could take their policy with them.

Mr. President, the Dole bill, also called the American Option, will outlaw discrimination against the sick, the injured, and the dying—the very people who need health care and insurance the most. It will prohibit insurance companies from excluding preexisting conditions from their policies.

The American Option will create medical savings accounts, similar to IRA accounts, so that people can save money tax-free for their medical needs. Six States have changed their tax codes to accommodate medi-save accounts. They do not pretend to provide for catastrophes. But, by giving Americans the ability to save for their minor medical expenses, we can bring competition back into that system and bring down costs the real way. Medisave accounts give patients the ability to use money that would otherwise be spent on insurance company overhead. The Clinton and Mitchell bills will not allow medi-save accounts.

Time and time again, Mr. President, the Clinton administration has used horrible stories to sell its plan. Yet the stark truth is that the Dole plan would prevent those horrible stories, and the Clinton plan would bring new horrors down on the heads of the people he has brought into his press conferences and all other Americans as well.

Our system is strong because we have good doctors. They are well-trained, they can choose a specialty, and they can choose the type of practice in which they can excel, and they can offer their patients their best professional advice, plus the security of a stable doctor-patient relationship.

Americans take their liberty to choose doctors for granted. This relationship, and doctors' freedom to offer the treatment they think best, is as old as the medical profession, and quite frankly, it is what makes medicine a profession. Certainly, if patients have concerns about one type of treatment, they can raise them with their doctor and the two of them can discuss the options confidentially and agree on a choice.

Mr. President, the Clinton and Mitchell bills insert the cold hand of Government into this private discussion and tell doctors and patients what sort of care will be covered and what sort will not. There will be an engineering from Washington, DC, engineering of the type of care and which doctors can go into a specialty area. The National Health Care Cost and Coverage Commission, the National Health Benefits Board, the Commission on Workers Compensation Medical Services, and the National Council on Graduate Medical Education are just some of the new bureaucracies that Clinton and Mitchell will create.

The administration said it was going to create new jobs in our country. Now we know what he meant—new Government jobs, new bureaucracies.

These bureaucracies will be powerful, and the power that we will give them now resides in the American people. It will be a massive takeover of the free enterprise system and a transfer of personal liberty to Big Brother in Washington.

When you turn to the Dole bill, you will find that it establishs no national health boards, no other Government agencies, because the Dole bill leaves those choices to doctors and patients. If we pass the Clinton-Mitchell type bills, we will have all of the new bureaucracies that I listed. If we pass the Dole bill, we will have none. A major problem in our system now is the growing crisis in medical liability. Medical malpractice suits have inflated the cost of health care delivery in the United States and it cuts access to patient care. Yet the only bill before us that seriously addresses this problem is the Dole-Packwood bill.

On this issue, as on so many others, the States are ahead of Washington; 21 States now have some limit on damages, and 12 States have limits on attorneys' fees.

The Dole bill caps noneconomic damages at $250,000. That is exactly the cap the State of California already has. But the Clinton and Mitchell bills not only fail to provide a Federal limit, but they also preempt the laws that are now in place in the State of California and every other State that has been able to rein in malpractice damages and the economic harm they cause.

I would like to read a few letters from individuals that I have received against the Clinton plan.

This is from Harry and Anita Kattegat from Grovetown, GA:

By now I guess that you can imagine why we are so concerned about the current Health Care Reform efforts. In its rush to "fix the system," Congress must consider the millions of Americans who have insurance and how they will be affected by some of the proposed changes. Let's focus on the people who really don't have any health care, and not destroy or downgrade what the large majority of Americans have.

Keep government out of the health care system. We must maintain "Freedom of Choice" and not resort to some form of health care rationing.

And from Jayne Hover, who signs it "Jayne Hover, Citizen," from San Antonio, TX:

The issue of health care has greatly disturbed me. I totally agree that the current system is not efficient for every individual. But I strongly disagree that the answer is a federal system. To repeat what so many of you are saying on this issue. * * * Show me even one area that the Federal Government has taken over and done better than the private sector.

As you have expressed your frustration over not being in closer contact with the people back here in Texas, I too am frustrated that we, the American people, are not being listened to in Washington, DC. I am amazed that folks who have been placed in office, I believe, to express the wishes of us who can't go to Washington would choose to not express the wishes of their people whom they represent. * * * It is regrettable that such an attitude prevails in Washington, DC. I am asking you as my representative * * * to please hear my voice and do everything you can possibly do to stop the health care profession from coming under the control of Washington. The amazing thing to me is that I have heard people say that they know the way things are now isn't perfect, but not one person I speak to is in favor of the federal government taking it over. Is anyone listening?! Just because a system is faulty doesn't mean big government can come in and make it better. We aren't asking Washington to do that! Who is?! There are clinics all over the United States. Walk into one and ask yourself if that's the way you want to see a doctor in the future. Right now it's bad for some folks (and that's not good), but if this program gets passed, we will all have equal care—equally bad care!

And this letter is from Austin, TX.

DEAR SENATOR HUTCHISON: I am writing to tell you I am worried, no, more than worried, scared of what may happen to us if this Clinton Health Plan (or one like it) should be passed. * * * I am 68 years old, my husband is 70 years old. He is retired military enlisted. I have many health problems, but all are under control with medication and the supervision of a good doctor. I had hoped to keep him until I die. If this health plan should pass, I may not have that choice. * * *

I know your job is not easy and I do not presume to tell you how to do it. I can only ask that you watch carefully that they don't push something through in a hurry and we will all suffer in the end.

From Mrs. Dorothy Tillman.

And this letter, from Hurst, TX, Natalie Cooper.

Though I am just one of many residents in Texas, I ask that you please consider my experience with our health care system as you plan to influence its future. * * *

I am a 23-year-old resident of Hurst who formerly pursued a music education degree at Baylor University before becoming seriously ill. I have been disabled for the last two years of my life and ill for the last five. I firmly believe I would not be on the road to recovery if I had been forced to receive care under the proposed health plan. * * * Instead, I would be on the road to death, if not there already.

I have been through a series of tests and diagnoses ranging from multiple sclerosis to my illness being a figment of my imagination. * * *

Yes, my insurance, like so many others, was canceled. Social Security denied me disability, and the medical costs have consumed my husband's and my financial resources. Our insurance system does need improvement, as does its availability, but dooming our successful medical system to one of socialistic demise is outrageous!

The Clinton plan isn't about health care. It is about the lifeblood of America—Freedom! To know that such atrocities are even considered in this country is frightening beyond that which words cannot describe.

Mr. President, I would now like to address the charge of gridlock, which the President's supporters have frequently leveled against the Republican Members.

A study of the debate during the writing of our Constitution makes clear that the reason the legislative branch of Government was created was to consider closely, and debate carefully, legislation that profoundly affects our Nation. We are supposed to weigh the values and interests of the people we represent and do what we think is best for them. We were not elected, and this Chamber was not constituted, to be a rubber stamp for the President, no matter how impassioned his challenges.

A great legislator, Edmund Burke, said, "Where the great interests of mankind are concerned through a long succession of generations, that succession ought to be admitted into some share in the councils which are so deeply to affect them." Think, therefore, of the generations after us who will build businesses and raise families in the Nation we leave them.

If we think the Clinton-Mitchell plans are dangerous, and I do, then we are required by our oath of office not to pass such laws. If we think we have better ideas, and I think we do, then we must propose them.

And if our proposal is not passed and we face a choice between passing no bill or passing a bad bill—I believe it is my duty to object to passing a bill that I think will hurt future Americans.

If a good bill must wait until next month or next year, I will do everything I can to make sure that it waits.

No amount of bullying from the President will persuade me to sell my constituents into a world of long lines, new taxes, and bureaucrats rationing treatment. The President can rail against us from a bus, but I will not abandon my countrymen's liberty to a National Health Board.

Mr. President, the American people do not want a Government-defined standard benefits package. They want to choose their health care in the marketplace.

Our forefathers who founded this Nation were independent and self-sufficient. The Clinton-Mitchell plans would take away that individual choice and decision. While universal coverage is a worthy goal, it is also an impossible one. Hawaii and Canada have proven that. On the other hand, universal access is not impossible. Let us give the American people choices, not mandates. Let us give them the American option.

Mr. President, a few weeks ago we learned that the Vice President of the United States holds dinners for Washington luminaries to discuss Metaphor. Not metaphor in the sense of a correlation between literature and life, but succumbing to the notion that theories of subatomic physics can explain human social interaction. I find this not just amusing, but also illuminating. It may be a Washington disease to try to explain human action in other terms, and I think it is a good bet that the designers of the Clinton plan have been dining with the Vice President.

Mr. President, we are being asked to spend the next 2 weeks voting on a rapid series of detailed amendments to an enormous bill that will capture one seventh of our economy. We are taking up a plan that adds billions to the deficit, is anti-liberty, anti-small business and pro-bureaucracy, and we are trying to whip it into a good reform in 2 weeks.

Mr. President, when you have a horse with four broken legs, you do not ride it. You put it out of its misery and find a different horse.

I cannot stop this charge by myself. One of the oldest moral lessons in our civilization tells us always to act as though what we do makes a difference, even when we have no assurance that it will. That is why I stand here on the floor of the Senate opposing the efforts of the President of the United States.

We owe it to our Nation to make another choice. And there are really two options before us. We could put the clever commercials off until next year, and then begin the debate anew with a clean start and plenty of time to deliberate and study what we have learned during this Congress. Waiting, and building on what we have learned, would be far better than hastily passing a bad bill.

Or we can pass the bill offered by the Republican Leader. It is a good bill. It will provide access to affordable insurance for every American, rich or poor, young or old, sick or healthy. It contains sensible reforms and preserves liberty and quality. If its turns up a few weaknesses after a couple of years, we can address those with future legislation. But passing the Dole-Packwood bill will not put our growth and our security at risk. That is the choice I advocate today.

If we approve the Clinton-Mitchell approach, we enter a nightmare system of Government coercion, rationed health care, new taxes totalling $100 billion dollars, special punishment of Americans who have made sacrifices for good health plans, intrusion into the doctor-patient relationship, loss of jobs, reduction of wages, and harm to our Nation's fiscal, economic, and medical health—a harm, Mr. President, that can never be reversed.

We can reverse bad tax increases and we can reverse bad regulations, but, Mr. President, how can we put a broken health care system back together when the quality is gone? It would be like patching a broken egg.

President Clinton can go on television and tell truly sad stories from which he draws false conclusions. He can call those of us who oppose rationing, and mandates and new spending and new taxes and government control of health care, obstructionist. He can practice whatever desperate measures he wants to make radical changes in American life, but I will not yield.

Henry Wadsworth Longfellow, our great American poet, said that "We judge ourselves by what we feel capable of doing; others judge us by what we have done." I submit to my colleagues that we are capable of expanding access to health insurance for those who lack it, without consigning those who are insured to Governmental control, and without harming the quality of care, our economy, our liberty, our medical training, or research. If we pass constructive change like the Dole bill, then our grandchildren will look back on our choice with gratitude, and will be able to judge us by what we have done, and to believe that our course was wise.

The PRESIDING OFFICER. The Chair recognizes the Senator from Minnesota, Senator DURENBERGER.

Mr. DURENBERGER. Mr. President, I have a brief comment. Of course I do not know that I agree with my colleague from Texas about the possibility of putting health care reform off until next year. I hope we would do it this year. But I must say and must reinforce what she said about the importance of doing it right. I think that is the bottom line in her presentation.

Not only are we talking about one-seventh of the economy, we are talking about a system in which 50 States—some part of 50 States have been sending us messages and signals for a long time about the need to do national reform so they in their communities can

respond. I do not think we are going to change the system if we found we have made a mistake—we are not going to change it.

The other thing I appreciate her reminding us of again, I just thought of this in the last 24 hours or so and was reminded of it an hour or 2 ago, this is not simple work we are doing. You do not just pick this thing up and pick through it and find your favorite solution. I recall President Clinton, when he came to office, promised he would do health care reform—would have a bill up here in 100 days. The bill did not get up here until almost 300 days after he made that statement. Why? Because he was lazy? No. Because he lacked commitment? No. Because it is a very, very complex issue. It is very difficult.

So no one should be too surprised, even though we have sort of been at this issue in one way or another, that on the floor of the Senate, a lot of us on both sides of the aisle who have not been involved in one or the other committees, want to spend some time not only reading the bills but discussing some of the principles that are involved, because they are of such critical nature.

So I compliment my colleague from Texas for that contribution and for all of the contributions which she has made and will continue to make to this effort.

Several Senators addressed the Chair.

The PRESIDING OFFICER. The Chair recognizes the Senator from South Dakota, Senator DASCHLE.

Mr. DASCHLE. I will yield such time as he may consume to the Senator from Nebraska and then I will yield to the Senator from West Virginia.

The PRESIDING OFFICER. The Chair recognizes the Senator from Nebraska, Senator EXON.

Mr. EXON. Mr. President, before I make the remarks that I am about to make, I would like to repeat what I told the Senate Friday last when I discussed this matter. I said then, "I come here with rancor to none, with accusations against none, with an understanding of the passion that grips Americans and Nebraskans on this health care issue, and with the understanding of the strongly-held views by my colleagues of all persuasions."

I go on to say that I rejected the President's bill some time ago. I was looking at the other bills that are before us. I hope we could reach compromise. I pleaded for debate that would be informative, as truthful as possible, and not to get off on tangents.

I have been listening to the Senator from Texas. There are several things I think need correction. While I would say that there were many good remarks made by our colleague from Texas, in the remarks she has just finished, once again the Senator from Texas has been the typical case of several of the presentations made on that side of the aisle. They talk about mandates, mandates, automatic mandates, mandates. That is a scare tactic.

The representation of the mandates in the Mitchell bill—that I have not agreed to support—but I am looking at that bill and others, trying to be objective. Let us, once again, set the record straight on what mandates are in the Mitchell bill. The Mitchell bill has no mandates in it at all. It simply says that if the bill does not reach the goal of 95 percent coverage by the year 2002, then the board or commission would make recommendations to the Congress as to how we would reach that goal.

The board or commission at that time would not be unlike the Base Closure Commission, which makes recommendations to the Congress, and we are all familiar with that. It is very similar in nature.

It makes recommendations to the Congress to as to what we have to do, now that we have not met the 95-percent coverage that we hope we will meet at that particular time. It then goes on to say that if the board makes recommendations—and there is no assurance that the board would put mandates in there—to the Congress, and then if the Congress ignores the Board, takes no action whatsoever, then and only then would the mandates, that 50 percent of the cost by the employer and 50 percent by the employee, only then it would kick in.

I would simply emphasize once again that before mandates could go into effect there would be ample time, ample reason, every opportunity for either the House of Representatives or the U.S. Senate to step in at that time and say we are not going to have any mandates. So the mandates, way into the future on this bill, would only take over if the Congress of the United States fails to take action. But even at that time, I would point out that Senate and that House could overturn the mandates by a simple majority vote.

So mandates have been blown all out of proportion, as if they were the same mandates in the original Clinton bill, which they are not.

I also have heard some statement that we have a competitive system in the United States of America. We sure do. It is a competitive system. I agree, we deliver good health care to those who have coverage. But it is not good for all the citizens of the United States. Competitive system? It sure is. But I would simply say that too many people on both sides of the aisle are overlooking the fact that the Mitchell bill, the Dole bill, the Moynihan bill—and there are others—are trying as best they can to address the matter of costs. We have a competitive system but the costs are going right through the roof.

Just one example of that. Certainly the people of the United States who pay premiums monthly for their health care recognize that they are reaching a point when they cannot afford to pay for what they have. Medicare and Medicaid cost the U.S. Government $9 billion in 1970; $137 billion in 1990; and it is projected to go to $458 billion by the year 2000. We have to do something.

So let us continue to talk in a fashion that is reasonable, not making false claims and accusations as I indicated in my speech Friday, but to see if we cannot come to some kind of compromise and bring us all together.

There were statements made about the Canadian plan. I am not a supporter of the Canadian plan, that is a one-payer, socialized system. But I have talked to many Canadians that like their plan very, very much. My wife, when we were in Canada one time, went to the hospital under the Canadian system. We were treated very well.

The Canadian system is not as good as ours and the Canadians know that. They have never had as good a medical system in Canada as we have here, and we can be proud of that.

But talk on the floor of the Senate that seems to try to relate whatever failures there are with the Canadian system—and there are some—as part and parcel of what we will have, the same coverage like that in America if we pass the Mitchell bill, is nonsense. There is no real resemblance between the Canadian plan and the Mitchell plan. They are totally different. And I think it is not fair, it is not proper to try to use those kinds of tactics and statements, because I think they tend to confuse the issue rather than address it squarely.

I say again, in closing, that I am looking at all the plans. I think there are some good parts in all of the plans. I am not committed to vote for any one. I am going to see what amendments are put on to control the costs, above everything else. I cited the costs on Medicare and Medicaid. If those costs are high, what do you think has happened to the premium of Mr. and Mrs. John Q. Public?

We are trying to address costs. I have not decided yet which one of the plans best controls costs, or would continue to provide the health care that we want and expect and are going to have in the United States of America.

I simply say, Mr. President, that I hope that we can talk about these things objectively and fully understand some of the basic principles of the Mitchell plan and forget talking about mandates, automatic mandates. They are not in the bill, and we should have a clear understanding of that.

I thank the Chair, I thank the Senator from South Dakota. I thank my friend from West Virginia for allowing me to go first.

Mr. DASCHLE. Mr. President, let me thank the Senator from Nebraska for

his clarification and for, once again, drawing attention to the fact that there has been a good deal of mischaracterization about the Mitchell bill and about many of the provisions in several of the bills that are currently pending before the Senate.

Obviously, that is one of the purposes of this debate: To be able to sift through fact and fiction, to be able to lay straight the mischaracterizations, the misinformation, and he certainly has contributed to that this evening. I appreciate his contribution a good deal.

At this time, I yield to the distinguished Senator from West Virginia such time as he may consume.

The PRESIDING OFFICER. The Chair recognizes the Senator from West Virginia.

Mr. ROCKEFELLER. Mr. President, I thank my very dear friend, the Senator from South Dakota, who is just pouring unlimited energy and integrity into this battle. I note, just before I make my remarks here, sort of a nice irony and circumstance, that the two gentlemen on the Republican side of the aisle who are here—Senator DURENBERGER and Senator CONRAD BURNS—are very, very dear friends of mine, people that over the years I have been able to work with very easily and very well on very important matters.

That gives me comfort, Mr. President. It gives me hope and comfort as I look to these coming weeks because I can remember the Senator from Minnesota who I admire very, very much and who taught me everything I know about health care. I have worked with him on a number of things. I can remember one, wonderfully obscure but very important piece of information called the Resource Base Relative Value Scale. We were working on it together and our staffs were together, and we came to a critical point in the negotiations against those on the other side of this issue. We were seated in the Senate dining room, and we decided to do nothing.

By the act of doing absolutely nothing at that particular moment, the other side caved in and we won. There have been many other examples—working on the Pepper Commission with Senator DURENBERGER, exchanging ideas on many, many occasions with him. It has been an honor to work with him, a pleasure to work with him and a very constructive experience for this Senator to work with the senior Senator from Minnesota. I enjoy the fact very much that he is here. I would like to think of that as emblematic of what could take place.

And I see Senator BURNS, who is clearly fascinated by what I am saying because he is lost in his newspaper there, but he and I have worked together on the Commerce Committee on a number of occasions. We work together all the time on NASA matters, on technology matters. I remember one of the bills that was most crucial to Montana, to West Virginia and to the country called S. 4. It has to do with competitiveness technology—a whole lot of things. It is a very, very important bill, not very well known.

The party Senator BURNS represents was not necessarily in full agreement with parts of this bill. But the people who Senator BURNS represents, he felt, could not get their just due unless this bill came to fruition. It was a remarkable experience just to watch him and to work with him as he just went ahead and did what he thought was right. We prevailed in the Senate. We worked together in the Senate on that, floor managed together in the Senate. It was another example of both parties working together and coming out with something that was constructive for Montana, for my State and for the country.

I just take note of that, Mr. President, and I am very happy with that.

Mr. President, I did some reflecting yesterday on what we have seen and heard—I guess particularly heard—over this past week. And I keep thinking about the millions and millions of Americans listening in, trying to figure out the accusations, the charts, the endless volleys of words that go back and forth like extended tennis rallies.

Out of all of this, I think one very clear, very simple fact has emerged; and that is that the Senate is divided over health care reform. In many ways honestly divided.

There is one group that wants to pass a bill to fix the wrongs of our health care system, and some of its Members have been here on the floor arguing for the majority leader's plan, the so-called Mitchell plan.

Others, we hear, are still trying to sort through what is most important to them in defining a bill that is worth passing, that deserves their strong vote.

And then I think there is clearly another group that feels very threatened by the very idea of a health care reform bill passing at all.

I hope, Mr. President, and I pray that we will discover that this group represents only a fraction of the Senate, and I believe in the end it will. I am optimistic by nature. I need to be that way. I have to be that way. I want to be that way. I know from years of working with Senators, like Senator DURENBERGER and Senator BURNS, on health care on both sides of the aisle, as well as the distinguished Senator from Nebraska, that there is a majority in this body whose hearts and heads are gravely concerned about real problems in health care facing our people.

You cannot be in the profession that we are in, the craft that we practice and not run into serious situations where one is genuinely moved by family circumstances that you see, people who are caught without health insurance or who are caught where they are really hopeless against forces far larger than they are, which is why we are here.

But, on the other hand, having reflected on this, there is really nothing very new about the fact, the very clear fact, that some Senators are determined to—and I emphasize some Senators, not all—prevent the rest of this body from working out something to deal with a very major social problem.

Most people, when they talk about the health care reform bill, refer to this as the most important piece of social legislation in the last 30 or 40 years, 50 or 60 years. Social Security was tremendously important but, in a sense, it was an add-on. Medicare was tremendously important, but it was an add-on. This is reform. This asks a lot from each one of us and is complex by nature, contentious on the merits intellectually and very difficult.

The Senate has had naysayers and delayers in the past on this floor trying to kill off virtually every major piece of legislation dealing with an important issue in the lives of Americans. There are some even on the Democratic side. You pore through the history books and CONGRESSIONAL RECORDS and you will find relief in that the current situation is by no means unique. I think the stakes are higher, but the situation is not unique.

Some or many Senators threw their verbal spears at Social Security, at New Deal programs, at Medicare, the civil rights bill. Senator DOLE, on television yesterday, indicated that he voted against Medicare a number of years ago in 1965 and still had that same view: That Medicare was not the right way to go at it; there was a better way, in his judgment. People balked at civil rights bills and environmental protection bills. At the idea of guaranteeing a minimum wage—the concept of increasing the minimum wage can create an enormous firestorm in this Chamber—a safe workplace, reliable prescription drugs, creating the Food and Drug Administration, uncontaminated food, even toys. Toys that will not kill children still demand the attention of Government. You have to step in sometimes to protect consumers, which is in a sense what Government has to do. Government protects our people as a whole from foreign enemies, and we have to protect practices within our own society; we have to protect our consumers from events and practices which are not safe or proper.

(Mr. AKAKA assumed the chair.)

Mr. ROCKEFELLER. The list goes on and on. I confess I really hoped that it would be different this time, particularly on this subject. I care deeply about health care. I care passionately about health care. And here we are, talking about a problem that preys on

and threatens Americans in every single State with no exception, and in many places with not much variation, in every part of town, among every age group, from birth through the very last days of life, among business owners, minimum wage workers. Any group that you can think of, they are afflicted, preyed upon, and unsuccessful in dealing with something called a health care problem.

Now, what do all these people, all Americans have in common today? What they have in common is not being able to count on their health insurance when they need it. It is just as simple as that: Not being able to count on your health insurance when you need it, having the fear that the day the doctor says that you have a tumor, that you get pregnant, or that you need an operation is the day that the fine print in your insurance which you were given by your employer or which you negotiated but failed to read the fine print, that the fine print in your insurance plan takes over and, frankly, walks right over you—not being able to hold onto your health insurance when you change jobs or lose your job through no fault of your own. Perhaps your company is downsizing; you are out of a job, get wiped out of a job because of, perhaps, an unfair trade practice. These things happen, having to fear the day that you get the pink slip or the moving truck comes is the day that the footnote in your insurance plan takes over. And that little footnote says sorry, we do not have any need for you any longer.

Mr. President, the point of the Mitchell plan before this body is to put a stop to this. It is the main point and thrust of that bill, together with working toward universal coverage.

The only thing the Government is doing here is to say that health insurance should be there when you need it. And I think it seems not unreasonable for the Congress to insist on that, and insist on that in very clear terms. I think the American people expect that of us, and I think we should be expectant of ourselves to be able to deliver that to them.

So let me tell you in just a word what is good and sensible and sound in Senator MITCHELL's bill, and why this bill is the most reasonable and rational place to begin working on health care reform.

Start with the fact that the Mitchell bill provides a path to universal coverage and pursues it in gradual and moderate steps.

It allows, in a very definite timeframe and without burdens on business or Government takeovers, the market system to work. We want each and every American to count on reliable, effective, affordable health care coverage that can never be lost or never be taken away. Anyone fearing a massive overhaul by Government should listen up. There is no heavy Government hand at work here. There simply is not. And we will have a chance to discuss this as we get more into the debate.

So far, most of the attack has come from the other side, and relatively little of the defense has come from this side. But the defense will come at the right time and in the right way.

The Mitchell plan gives the health care market—the free market, the competitive market—the first chance to fix itself by allowing market forces and competition to keep prices down. The CBO believes that they can do that and at the same time achieve coverage for 95 percent of all Americans.

It penalizes abusers of the system in order to help phase in benefits for children and pregnant women. The Senator from Minnesota will remember very well on the Pepper Commission back in the 1980's, that was one of our top priorities. And that is where we ought to start on health care reform, with pregnant women and children.

It is absolutely amazing to me, astounding, stunning, unbelievable, that in America, not in every case but in most cases, if you are a young woman and you get married and you do not have health insurance and you become pregnant, you have a preexisting condition and most times you cannot get health insurance. If there is anything that requires health insurance it is being pregnant. But that is classified as a preexisting condition in most insurance policies and is an uninsurable event. In America, that is extraordinary, not something of which to be proud.

The Mitchell bill's plan has a foundation that rests very firmly on preserving the strengths of our current system. It does not turn it upside down—no Government takeover—but preserves the strengths of a private guaranteed, job based insurance market, just the way it is today, the way people are fundamentally comfortable with it, and then easing in reforms to fix the faults.

That is the major change between the Clinton bill and the Mitchell bill. The Clinton bill was much more aggressive. The Mitchell bill takes a more careful posture, trying to reach out to more people, to make itself more amenable, more comfortable, so people feel more free to embrace the idea as a plan that one can trust and put one's faith in.

If there is one general guide to the Mitchell bill, it is consumer protection. And that is a very proper guide and a very proper role. I come back again to misleading fine print. There is a lot of it in the land, Mr. President. The Senator from Minnesota and I and Senator DANFORTH and others were very involved in reforming medigap, a $15-billion industry at the time, a few years ago. The whole problem was that there was so much fine print, and people preyed on seniors, and people worked on commissions and so often seniors were buying much more insurance, medigap insurance, which in a sense fills in for what Medicare does not provide, and they were buying more than they needed.

Salesmen would come to the door and make a persuasive case. The senior would not necessarily agree, and like most of us might not agree with the fine print. So they were paying too much for overlapping, and in some cases simply absent, benefits.

So misleading fine print and deceptive practices are stopped cold by the Mitchell bill. "No lifetime limits." People are going to have to be very familiar with that phrase: "No lifetime limits." Most insurance policies these days have the amount of money that you can spend or your insurance policy will spend for you on your health care. But when that runs out, it stops. Well, we do not allow that in the Mitchell bill. "No lifetime limits," an extraordinary combination of three words, and a very powerful phrase; no refusal for serious illness. If you get cancer, the insurance policy stays right there. Nothing changes. Not even for one moment do you fear that somebody will come in and raise your rates or take your insurance away. The thought will not even occur to Americans because nothing will happen. The insurance will stay there. It will remain there, no matter what the disease or what the problem.

And for seniors, long-term care and prescription drugs is pretty basic stuff, but very, very important. Long-term care, particularly community and home-based care, is much less costly than hospital care, and much less costly than nursing home care. Sometimes hospital care is needed. Sometimes nursing home care is needed but very often it is not.

Whenever you go into a nursing home—I know the Presiding Officer has been to many to visit his constituents and others—the rooms in the nursing home are always made to look much like the rooms at the home that the person left. Of course, the reason for that is the person would rather be home. So in the Mitchell bill, we emphasize home-based and community-based care; and, especially, Mr. President, to those people who work so hard is all of this significant, who play by the rules, who pay premiums but still get dunked—inexplicable to them—and cut off when they need insurance the most.

We do not have to worry in Congress, do we? Our health care is paid for by a combination of ourselves and the American taxpayers. It is the same with Federal employees, and the same with the President. We have made that arrangement. We have made that arrangement for ourselves to take care of ourselves and our families. Then the

American people would have the right to ask, "Would it not be fair that we would get the same kind of arrangement that you, who work for us, and who receive our taxes so that you can have a salary; that we should have the same kind of arrangement?" Well, I think that is fair. I think most Americans feel very, very strongly about that.

For those families now struggling with the health care burdens, the Mitchell plan offers help to make ends meet. Rates cannot be arbitrarily jacked up. They can be now. An insurance company can unilaterally on its own decision simply take your rates and increase them by 20, 30, or 40 percent if you are a small business. They could do it because it is the end of a year, or they could do it because let us say one of the 10 people in that small business had come down with an illness and they wanted to minimize the risk, minimize the chance of losing profit. So they jack up the rates. That cannot happen under the Mitchell bill. Insurance will be affordable, and insurance will be dependable.

All of this adds up to a bill that is good for the American people, that is moderate and sensible, and not intrusive, and not punitive in any way; using the system that we have, building upon it, and then fixing some of the flaws that exist. It will be a private system of guaranteed health insurance, and not Government health insurance. People will not pay their premiums to the Government. They will pay to a private health insurance company just as they do today.

Still some are offering up Senator DOLE's, what I would call tinkering proposal, as a better alternative. I do not see it that way. I do not see how others could see it that way. For starters, it does very little to protect consumers. Again, that is an area where Government has a legitimate right. We protect the country from foreign enemies. We ought to be able to protect consumers of health care on basic matters. There is very little of that in the Dole bill. All of those loopholes, all those restrictions that work against consumers, all of these things which I have mentioned which are eliminated in the Mitchell bill will remain under the Dole plan were it to be passed.

There is no guarantee in that plan of decent coverage, and no assurance that coverage will remain portable. Remember I talked about jacking up rates. That can happen in the Dole plan. There is no preventive care coverage. It is gone with the Dole plan.

I listened to Senator DOLE and Senator MITCHELL yesterday on a Sunday television program, and the final thing that Senator MITCHELL said was that the thing which is closest to his heart, that he cares most about in health care, is primary care and preventive care. So it is carefully observed in his bill, and is widely ignored in Senator DOLE's bill. If you fall seriously ill, and need your insurance, do not count on it under the Dole bill. Under the Dole plan, the fine print which today lets insurance companies cut and run stays in place.

For seniors, the news is no better under the Dole plan. Medicare gets cut as it does under the Mitchell plan but you get nothing back for it; no new coverage. Under the Mitchell plan, of course, it is very different. In the Dole plan there are no prescription drug coverage. In the Mitchell plan there is prescription drug coverage. For seniors that is important. It is their major expense. There is no long-term care in the Dole plan. But there is in the Mitchell plan. For seniors, long-term care is everything. It is everything, and for all of us parents, grandparents, and friends, long-term care is perhaps the most essential, sustaining continuing, agonizing part of health care.

If you lose your job, or if you get too sick, or if you own your own business, or you just get old, I will tell you what BOB DOLE's health plan says to you. It says basically that you are out of luck. Health care should not be a matter of luck. It should not be left to quick-fix half-measures. I am afraid the Dole plan is in that category. Think about this. In the United States today we make sure that the electric company and the gas company and the telephone company cannot just operate recklessly. They are subject to a public service commission, cable—something so American as cable. We make sure that utility rates cannot be raised suddenly without review by a public body. That is called consumer protection, which is widely understood and appreciated. And we make sure that service cannot be cut off arbitrarily, because in America people are not left sitting in the dark and the cold to freeze to death. We do not do that with our people with utility bills, and we should not do that with health care, which is at least, and probably substantially more over the long-term, important.

Well, health care is just as essential. It should not be left to some inexact, ineffective certain rules. Consumers deserve as much protection and consideration when it comes to health care, and the Mitchell bill provides that consumer protection.

The Mitchell plan, as I have indicated, is moderate and thoughtful and uses, in many ways, a rather light touch. It is sensible as an approach, seeks to be effective but not intrusive. I would hope that approach would be appreciated, and I would think that that approach would be applauded. It is pretty rare around here to take such a reasonable tack, and it should be, I think, appreciated.

So, in conclusion, I just hope, Mr. President, on this evening that my colleagues can finally focus on the strengths, stop offering up lesser plans as equals, stop wasting time because time is now precious, and join me and many others in a determined effort to begin building on Senator MITCHELL's plan to pass health care in this Congress.

I thank the Chair and my friend from South Dakota.

I yield the floor.

Mr. DURENBERGER. Mr. President, I appreciate the opportunity to make a few remarks. Before I do—and I intend tonight to speak not only on the bill itself, but also the Dodd amendment, which I understand is the pending business.

Let me acknowledge not only the respect I have for my colleague from West Virginia, but acknowledge how much pleasure it has been for me to serve with him in not only some of the projects he has already outlined but quite a variety of others which he has not. It only serves to underline, I think, the fact that the appearance of partisanship in the health care reform debate masks a tradition around here, as long as I have been here, of bipartisanship. I was pleased to hear him talk about the way we, together, used Medicare as a way to begin to reform the health care system in the 1980's.

I, in particular, will never forget not the time we sat in the dining room doing nothing, but the time that the then-chairman of the Finance Committee, Lloyd Bentsen, said, "I cannot get this RBRVS thing approved by the folks at Ways and Means, and I think I am inclined to just drop it."

Senator ROCKEFELLER came to me and said, "What do you think about that?"

I said, "That is not the right question, I am in the minority. What do you think?"

He said, "I think we ought to fight him." And we did and passed the bill. I must say the credit is to him.

In addition to other things, he got PETE STARK and HENRY WAXMAN, who were either not speaking to each other, or speaking in four-letter words, to come to my office one Saturday. I guess I was neutral ground, and we spent the better part of a Saturday hammering out the agreement which became the reform part of part B of Medicare. I will always be grateful to him for that experience, and others which I would love to share tonight, but I will save them perhaps for next month. I appreciate very much his comments.

Before I begin my comments on the bill, on a related matter, the place I represent and the people I represent in Minnesota are always being very creative in one way or another, and they have made an incredible contribution to universal coverage and universal access. The latest is another accomplishment by the wonderful nuns who go by the name of Carondelet LifeCare Ministries of St. Paul.

Sister Mary Madonna Ashton, who is a nun of the Carondelet Order and CEO of Carondelet LifeCare Ministries, has opened another free clinic, serving this time the uninsured and underinsured residents of the Twin Cities area around Wayzata, part of our community most people do not think about as uninsured and underinsured.

I ask unanimous consent that an article that appeared in the Minneapolis Star Tribune, August 15, 1994, describing the launching of this clinic and putting it in the context of universal access in our community, together with comments by the CEO, Sister Mary Madonna Ashton about the need for universal coverage, which she has conveyed to me personally, and not all with which I agree, be printed in the RECORD.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

A SMALL STEP FOR REFORMING HEALTH CARE—NEW WAYZATA CLINIC GIVES UNINSURED A PLACE TO TURN

(By Dan Wascoe, Jr.)

While Congress wrangles over whether to provide health insurance and adequate health care to those without coverage, a 10th free clinic serving uninsured and underinsured residents of the Twin Cities area is about to open, this time in Wayzata.

The clinics' doctors and nurses are all volunteers. Office space is donated. Patients need not pay a dime.

The St. Mary's Clinics, most of them open one afternoon a week, are sponsored by Carondelet LifeCare Ministries of St. Paul.

Since 1992, Carondelet has opened four clinics in Minneapolis, four in St. Paul and one in Spring Lake Park. Wayzata's will open Aug. 31 in the Interfaith Outreach and Community Partners center.

Why Wayzata, that tiny suburb on the shore of Lake Minnetonka?

"It isn't all riches and boats," said Sister Mary Madonna Ashton, the former Minnesota health commissioner who is Carondelet LifeCare's chief executive.

Cracks in the health insurance system appear everywhere, she said.

"That's something that people need to learn," she said.

The Wayzata clinic also will serve people in Hamel, Long Lake, Medicine Lake, Medina, Minnetonka Beach, Orono, Plymouth and neighboring communities.

Not all patients are expected to be chronically poor; many will be laid-off workers, employees of small businesses, single mothers and children.

The key is that they must not qualify for other health care programs.

St. Mary's Clinics are low-tech, low-budget operations. They offer such basic services as throat cultures, pap smears, ear checks, blood pressure readings, pregnancy tests and general physicals.

The doctors and nurses also have ties with specialists who provide free care when the clinics make referrals. The clinics also negotiate discounts for prescription drugs.

Even so. "Our Largest expense is medications, "Ashton said.

Some services, including emergency care, family planning and prenatal care, are not offered in order to keep the clinics' malpractice insurance rates lower.

Many clinics are located in churches, community centers and office buildings. LaDonna Hoy, executive director of the Interfaith center in Wayzata, said space normally used for the center's transportation office, volunteer coordination and newsletter production will be converted one afternoon a week to an examination room, a waiting room and a place to record weight and blood pressure.

Ashton, who was state health commissioner from 1983 to 1991 under Gov. Rudy Perpich, said Carondelet will open six to 10 more clinics in the Twin Cities area in the next year or two.

She and the state health department said they believe St. Mary's Clinics are the only strictly free ones in the metropolitan area. Others offer service on a sliding scale based on patients' income.

But she's less than confident that will happen, especially in light of last week's decision to delay the start of the health care debate in the House of Representatives. She's also irked by talk that "universal" coverage, even if passed by Congress, may mean 90 to 95 percent of the population instead of everyone.

She said she's "terribly worried" that those left uncovered will be the very people whom St. Mary's Clinics are trying to help.

If health insurance reform doesn't cover low-paid employees, temporary workers, the unemployed, employees of small businesses, women and children who aren't on Medicaid, then reform "is not addressing the problem," she said.

Even MinnesotaCare, the state-backed insurance plan that helps some residents who can't afford insurance, doesn't yet pay for dependents. And its premiums remain out of reach for some Minnesotans, she said.

Since the first clinic opened in 1992, Ashton said more than 4,000 people have been served—an average of 9 to 10 patients per four-hour day.

That's not much, compared to Ashton's estimate that 350,000 to 400,000 Minnesotans are without health insurance at any time. But Hoy said the care is particularly important to those who receive it.

Because of contributed space and services, the clinics's budget for next year will be only about $800,000, Ashton said. The volunteers' time is worth about $500,000, she said. The Sisters of St. Joseph provide about one-third of the total budget. The rest comes from donations from organizations such as United Health Care, the Phillips Foundation, the Woman's Club of Minneapolis and the North Suburban Hospital District.

A federal program provides money for breast and cervical cancer screening, and a state program underwrites pap smears, mammograms and colposcopy for vaginal examinations. An administrative staff of seven to eight employees in St. Paul takes appointments and performs other duties.

Pat Hein, the clinics' director of nursing, said St. Mary's has negotiated discounts of up to 100 percent for inpatient and outpatient care at five Twin Cities hospitals: St. Joseph's, St. John's, Unity, Fairview Riverside and Methodist. Negotiations are underway with North Memorial Medical Center. In any case, the care is free to patients; any hospital bills go to Carondelet, she said.

Although only a small minority of patients require surgery, "those who need it get it," Hein said. The most severe cases so far have been two patients who require mastectomies.

William McGuire, chairman and chief executive of Minnetonka-based United HealthCare Corp., said he strongly endorses both the idea behind the clinics and their performance. Although there's an abundance of hospital beds, doctors and specialized services, "we don't always have appropriate distribution of these things," he said "Importantly, it is not being executed other than through an organization like this."

Although Ashton would like to see the need for the clinics fade away, McGuire doesn't consider that realistic. Providing health services to specific uninsured groups will be necessary regardless of political health care remedies, he said. As evidence, he pointed to the founding of St. Mary's Clinics "in a state with one of the top two or three health quality measurements, one of the lower per-capita health-care costs,

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Mr. DURENBERGER. Mr. President, our colleague from Nebraska is not here, but while he was commenting on the statement by our colleague from Texas, he made quite a business out of saying there are no mandates in the Mitchell bill. Well, that just is not true. I am sure what he is talking about is the employer mandate to pay, although he was not that specific. I feel compelled—then, off the top of my head, without reading the Mitchell bill, remembering what is in the bill as I went through it—to say that he has to be talking only about this overt employer mandate to pay premiums, because in the Mitchell bill there are a lot of mandates.

I was informed by one of my colleagues today that the word "shall"—as in such and such an agency shall—appears over 2,200 times in the Mitchell bill—the latest version. To give you an idea of the mandates on employers and on working people, all employers in America, in groups of fewer than 500 employees, are mandated to join a cooperative. They are mandated to participate in community-rated risk pools. The employers are mandated to offer three plans, and they are mandated, if they make contributions, to make equal contributions to all three of the plans. They are mandated to offer the standard benefit package. For large employers, they are mandated to participate in the cost shift through risk adjustment. There is a specific provision in there that shifts risk from community pools onto large employers.

Large employers are required also—mandated—to offer three plans. Large employers are also mandated to withhold premium payments.

Having said all that and not having been totally complete in my description of mandates, I will add that mandates are not necessarily all bad. If a mandate means a national rule to which a market is going to have to adhere, then that is what we need. If mandates are a way to cost shift onto working people, or to cost shift onto businesses in implicit ways, then they are bad. That has been the consistent objection of everyone who has objected to employer mandates.

I will speak at another time probably to the issue of cost shifting. But the reality is that the cost shifting of doctor

and hospital bills in America is not coming so much from the uninsured, the businesses that do not insure their employees; it is coming from this place. The money that we do not commit to Medicare and Medicaid for the elderly, disabled, and low income, go to Hawaii in reduced payments to doctors and hospitals, come to Minnesota in reduced payments to doctors and hospitals. And that shift keeps getting wider and wider all the time. Today, I understand that on $1 of services at the hospital level, Medicare pays—the Government—only 71 cents, and for a billed dollar of doctor services only 59 cents. Where do you suppose the rest goes? The rest goes on someone else's bill in the private system, not in the Government system.

An employer mandate is simply a way to say we cannot raise taxes, we cannot go deeper in debt. What we are going to do is guarantee everybody in America you can enroll in a health plan and the costs of that will be shifted onto all the working people in this country.

Again, I will say I will have more to say on that subject another time, but just a reality. Every working person in America today is carrying the cost of his own in what he pays at work. He is bearing the cost not only of his own medical expenses but of one other family's medical expenses.

Just keep that in mind. If you have a GDP today of 14 percent, those people are paying about effectively 28 percent into the system, and half of it is going for someone else's health care.

At least, the Germans are honest about that. In Germany it cost 13 percent, 6½ percent from the employer and 6½ percent from the employee, and they get 13 percent worth of service. The overall cost in Germany is about 7 percent of the GDP, but in America we are doubling the burden on every single working person.

So those of us who have resisted the notion of a mandate that all employees have to pay are resisting the notion in this Congress, in this Senate we can continue to reduce our obligations to pay our bills in the Medicare and Medicaid system and cause all of those extra costs to be shifted onto working people. That has to stop.

Mr. President, at this time, before I make any further comments, I yield such time as he may need to my colleague, Senator CONRAD BURNS from Montana.

The PRESIDING OFFICER. The Chair recognizes the Senator from Montana, Senator BURNS.

Mr. BURNS. Mr. President, I thank my friend from Minnesota.

Finally, the time has come when we finally get to see a piece of legislation on the floor and being talked about even though it has only been here since Friday at 5 o'clock.

So, as we look at this, I was interested in some of the comments that were made earlier this evening as we started this debate tonight. Someone wanted to define gridlock awhile ago. Nobody has to define gridlock to us. We went through 4 years of it prior to January of 1993.

If you want to talk about scare tactics, what about the scare tactics that everything is going to run out and if the Government does not act to do something this country is going to come crumbling down on top of itself?

I do not think that is the case here in America. I think the American people are very inventive and have the ingenuity and the fortitude to take this country and go on.

I am reminded of my parents who bought a farm in 1931. I do not think there were very many white clouds in 1931. Not very many in this body can remember those times. I read a lot about and heard a lot about it. I was born in 1935, and I know the last thing you wanted was kids. But nonetheless those were pretty dark times. They did not have a thing called national health insurance. In the depth of the Depression there were scare tactics.

That this country would not survive without this Government acting I think is a little far-fetched. In other words, what are we going to do? Are we going to create the problem and then going to be the knight in shining armor to ride in and take care of it? But I am afraid that the solution is going to be worse than the perceived disease.

There are a couple of areas that I want to talk about tonight, and one of them is right here to my right, which is a map of my State of Montana.

My friend from Nebraska just now said that we are trying to address the costs of health care. That is what we are wrestling with. Nothing could be farther from the truth. We are trying to address the way to pay for it. At the heart of every one of these speeches is how do we pay for it? How do we come up with the money to pay for it? And how much do we want to spend on health care?

You can spend any amount that you want. But I think the patient and the people who need health care should make some of those decisions instead of the Government making it for them.

There are a couple of areas. This is the State of Montana. That is where I take my counsel. And to give you some idea what problems we have in our State, from way up here in Lincoln County in a little town called Eureka, down here in Carter County in a town called Alzada, it is farther than it is from Chicago to Washington, DC, and there are only 800,000 wonderful people who live in 58 counties in that great State.

So we have some problems to look at when you start talking about health care delivery systems. How do we pay for it? We have a lot to be concerned with, but mine primarily is, how do we cover all of this area where we have quite a lot of dirt between light bulbs?

I want to take a very close look at the rural health care provisions, the ability for patients to choose their services and their providers, their health care plans, the size of the new bureaucracy that will be created, the amount of taxes that are included in financing a huge big new entitlement, that is if it becomes a reality.

They say this is the greatest debate since Social Security. You know what I hear from some young folks who are saying, listen, you give me the amount of money that I put into Social Security and I can take care of my own retirement because the rate of return is not all that good for what it is starting to cost.

We also get letters about people who have been caught between a rock and a hard place and had some bad things happen to them, and you have to feel for those folks. You have to feel compassion for them, but there is a way to take care of those folks. But I am wondering, and I speak from being an auctioneer, how much emotion goes through when you sell out a person that has gone broke because maybe it is Government mandated, maybe its expenses got so high that they just could not stay in business. And when do we know where that breaking point is? It is not easy to go out and sell out a good friend in a bankruptcy. In fact, I think that is more crushing than anything that can happen to anybody in this country.

It is important that we not only read this bill but that we also have some kind of understanding of the impact that it will have on us. But more importantly, it is important that America gets the opportunity to read this bill and understand the impact it may have on them as individuals, because here in the United States we are still not to the point where they throw us all in a sack and shake us up and turn us all out and we are all equal.

Let me first say that I think the process we have gone through in the last 10 months has been very useful and very educational. I did not come from an area of the medical field. When I joined the task force on this side of the aisle to deal with some of the very problems that we are going to talk about here in just a little bit, I would say that I probably know more about it now than I ever cared to want to know.

Having a chance to understand what was in the Clinton bill, to review the impact on individuals and on companies in our State has led to maybe some positive changes, but it has also been mostly food for thought. It has tripped our trigger on curiosity. Maybe there is a different way to approach it. But that is what the democratic process is all about: Taking an idea to the public, getting their feedback, and proceeding with our constituents in mind,

and that is called responsible legislating.

I honestly believe it was understanding the Clinton bill and what it would actually do that led to the demise of the Clinton bill. Americans got ahold of it, they read it, they had a pretty good grasp and understanding of it, and then they said "no."

Not just special interests, but the people who vote, people who want to maintain their quality of life, and people who vote to preserve their family, people who enjoy their freedom and independence, those folks are the folks that I have been hearing from. They said they did not like the Clinton plan.

But do you know what else they said? My State of Montana was no different. In a poll taken in my State by an independent firm here in Washington, DC, 70 percent of Montanans say Congress should take the time, study the issue, and take action next year.

I do not know whether this is a prudent way or not, and I think maybe we might be shirking our duties if we did not try to do some tune up on a system that sort of needs a tune up.

Dorothy Bradley, the Democratic nominee for Governor in Montana and now the Chairman of the Health Care Authority charged with designing reform within my State of Montana, made the statement recently. In all the hearings she has held around the State, she found that "people have become very cautious about reform."

She said, "You don't have to embrace a whole new package to make significant gains. We are not going to work this through overnight." They want meaningful reform, but not just for reform's sake. And that is what has me worried here, is the timing. We are coming to the close of the 103d Congress and we are not well positioned to serve this issue or the American people very well.

We have here now a bill that has been crafted behind closed doors and yet, it seems to me that this is the Clinton bill reincarnated. The first chance we had to see what is inside it was just a few days ago. That was last Friday. Yes, the leader said we have been able to examine this for months. Perhaps, in concept, we have. But it was not put into writing until last Friday. It has been changed already more than a hundred times. Now we are expected to debate it, understand it, and even vote on it—all in a matter of days.

I have a great staff. I would have to have a great staff, because they wrote it into my speech. No, I do not want to say that. But I have no doubt if they had been working night and day—and they have been working night and day on this issue, trying to see what is in this bill, to grasp it and how it affects our State of Montana—they might even have been able to call a few people in Montana to get some feedback on the key provisions. But there is no way that the folks in the mountain time zone can have any idea what we are trying to decipher and disseminate and make some decisions for them. This is legislating in the dark of night.

We do not want to make this decision for them. We want them to make the decision and then tell us what to do. That is what we were sent here to do. We were sent here to listen and to carry those views out, what they think is best.

So the feedback from this great State, this great 148,000 square miles, is what I listen to. They sent me here to represent them. I am supposed to work with them.

This health care reform bill promises to be the largest program ever—certainly the largest I have ever worked on or voted on in my history in the Senate. I think it is only right that we have time to let our folks back home take a look at just what we are doing. No one will fault us for caution, but it is darn sure they will fault us, though, if we pass something that they know nothing about.

So given that, we have no time to discuss this with the folks back home, I think we need to proceed with even more and more caution.

My colleagues, especially those who sat on the Labor and Finance Committees, have a deep understanding of the details. And that is where really the devil lies, in the details.

I do not serve on either committee, the Finance Committee or the Labor Committee. So we have to do our work as it is presented to us, go through it, make sure our people are informed and make our decisions from there. I must concentrate on those areas that I know are important to Montana. Let us start with those.

First, it is crucial that this reform addresses the challenges of the rural health. When the First Lady visited Montana, she coined a new term. She called it "mega-rural." There are a lot of issues that need attention if we are truly to expand the access all across America. We have eight counties in Montana that are without a health care provider.

Can you imagine that?

I am going to turn up some maps here to show you just what we are talking about.

Eight counties that have no doctors, no medical care whatsoever. And we have to travel huge distances, so we have a difficult time recruiting where there is no support, and even a tougher time keeping them there. And we have now areas served by a single physician who wants to retire, but there is no one to take his place.

By the way, this county right here is Garfield County, MT. Only 1,800 folks live in that county. It is bigger than Delaware. And then, of course, we have some more spaces. But these are areas where we have no doctors whatsoever.

To magnify the problem in my State of Montana, the counties in red are counties that we have that are without ob/gyn—no prenatal care afforded those people.

And I think this area right here, the central part of Montana, is larger than the State of Indiana. So that is what we are talking about here when I say I have to look at my State and rural health care and how we regard it; and are we going to do something to give some incentives for doctors and nurses and technicians to practice medicine in these rural areas.

Second, Montanans want choice. That is what we are looking at. We are very independent. We do not want the Government dictating to us what services to have or what not to have or where to go get them. I cannot imagine there is a State in this Union that does. But, regardless, there are provisions in many plans that dictate just what kind of health care we should have. If the Clinton-Mitchell bill limits choice—choice of services, of providers, of hospitals, of health care plans—and I believe that this does—I will tell you that I have to strongly oppose those parts of it.

Cost containment comes when people can take some personal responsibility for their health care decisions. When they are given the information, they need to make wise and educated decisions. They will take cost into account. If control over health care choices is in the hands of the Government or any other bureaucracy, there is no incentive to be cost conscious.

I know it is hard to walk into a doctor's office and be diagnosed. I have always said, you know, doctors have a terrible time. Sometimes they intimidate you a little bit. But you walk in there, and they say, "Well, CONRAD you have to have your tonsils taken out."

And it completely shatters their whole life if you ask them, "What's it going to cost?"

They come back and say, "Why do you want to know?"

"Because I am going to go down the street and I am going to find somebody else that does tonsils and I am going to ask him what he charges."

That kind of gets their attention. We must never take choice out of this thing.

Third, health care reform cannot be allowed to destroy jobs or businesses, large or small. Consider my State of Montana; 98 percent of our businesses are considered small. So that is where my focus is going to be.

Yes, we have heard those stories about those people who have been caught up in a very, very bad situation. Again, I want somebody from this body to go down the street and be responsible for selling out of bankruptcy of a family that has gone on the rocks and a business that has gone on the rocks. Those small businesses are the people I

have heard from. And they are very, very loud. It has not been a whisper, Mr. President. They cannot handle more mandates; they cannot handle more taxes; they cannot handle the Government telling them how to run their business anymore.

The stories that have been relayed to me are real. They speak of laying off people. Those of us who have run businesses—and maybe some of them not too successful—know it is pretty easy to hire people. It is pretty hard to tell them that they have no job left, because an employer feels a responsibility to a family, not only to the working person they are involved with, but their whole family. They sort of take that personally—anyway, I do.

Let me remind you, this is the middle class. This is where the financial burden will fall, on these folks. The very folks we hit with tax increases last year are just about ready to be hit again.

There is no rational reason for businesses to bear the brunt of a new program. But if they think they can, they will—but it has to be voluntary. And given the choices, given the options, the vast majority of them do the right thing.

Fourth, and I have touched on this earlier, I want to keep the Government out of our lives. There are States where a strong presence of the Government is not there. In public lands areas, like the West, we understand bureaucracy—oh, do we understand bureaucracy, and what it takes to get things done. When you have to deal with the Forest Service, BLM, U.S. Fish and Wildlife, the Park Service, that is not to contend with OSHA, the IRS, EPA—just a host of Government entities, it seems like, are in your life every day. They do not run their bureaucracies very well, and I am wondering if I want them to run my health care system. Would it end up like the Post Office? Does my time to go get my hip replacement end up in a dead-letter office? I would sure hate for it to. I think Americans kind of worry about that, too.

So I don't like any plan that expands Government, that increases bureaucracy, or imposes more regulations on an already overburdened system. No new commissions—I do not like that very much—no new boards, no bureaucrats sitting in Washington, DC, this Government on the Potomac, deciding what is best for me in Montana.

The system needs streamlining; it needs simplification. But it does not need expansion. I have not heard one of my constituents say, "I wish I had more Government in my life."

Fifth is an issue that comes up with many farmers and ranchers in my State. I am from an agricultural State. I am from a natural-resource-based State. That is how we produce new wealth in this country. That is the only place we produce new wealth, is what comes from mother earth. The issue of allowing the self-employed to deduct 100 percent of their health insurance cost is very important to us. The last version I saw of the Clinton-Mitchell bill only increased this to about 50 percent. That is not enough. If we really want to help those folks who produce wealth, and I believe we all do, we need to give them a full break, and that is 100 percent. Large corporations get a 100-percent deduction for their health care costs, and the self-employed should have equal treatment. So let us do it. It is one big step toward making health care more affordable.

Sixth and last, and definitely not least, the bottom line is cost. This is one area that has caused numerous bills to stumble already. It is my understanding that the CBO has not yet figured out how much the Clinton-Mitchell bill will cost. We need a price tag on it. Without that, I am not going to go back home and even try to offer it to the people or try to sell it to the people of Montana. To establish brand new entitlements, brand new programs, expand Government, and impose new requirements on our States—and by the way, even with the majority leader's own words and with the communications with the Governors around the States, these mandates we put on the States to administer this are almost unworkable. They cannot get it done.

Those of us who worked in county government, where the rubber hits the road, understand, because it will finally fall at that level. Increased taxes, we got the biggest tax increase we have ever gotten in the history of this country last year. I am not really sure we can go through another one of those because I think that would be irresponsible. Montanans would oppose it, and I will join them.

I bring my concerns to the floor today because these are the concerns of the people of Montana that they are sharing with me. They want reform that makes sense in rural America. They want reform that guarantees choice. They want reform that does not jeopardize their jobs and small businesses. And they want reform without new Government bureaucracies, taxes, and mandates. Most of all, they expect and they want us to make wise decisions because what we do with health care reform will reach into their lives like no other piece of legislation passed in the last three decades.

I have reviewed the limited portions of this bill. I am glad to see the bill includes several provisions to increase access to health care services in rural and underserved areas. But is changing the graduate medical education focus to primary care important? It may be. But let me tell you, seeing those results is way, way down the road. I have a daughter, Keely. She is in her second year of medical school, and she is committed to returning to Montana, to work in rural Montana. But it will be years before she gets to that point. Rural America needs help now.

We need incentives to get physicians into the country: Repayment of loans, tax deductions, and peer support. The latter incentive can easily be accomplished by increasing the use of telemedicine. It is a new technology, a technology not only bringing specialty health care to areas where there is no specialist, but bringing much needed support to the providers. The technology is up and running in many States across the country, Montana being one of those. The only barrier is Government.

I was pleased to see the efforts to expand telemedicine included in this bill. I can remember when we just had to argue and fight and scratch and claw and fiddle around here to get a study done by the Department of Transportation on the impact that telecomputing would have on transportation. They did not want to do the study. And folks around here did not want them to do the study. But we got it in the bill. They did the study, and guess what? It is the centerpiece of transportation. Because there are going to be a lot of folks staying home 2 or 3 days out of a 5-day week and doing their work at home without filling our highways or using the gasoline and fossil fuels. Is it not funny how ideas take hold and all at once it becomes their idea? I have always had the idea around here if you do not care who gets the credit, you will get more done. That is usually pretty true.

These rural-specific provisions are important in this bill. But just as important is the rest of the package and what it will do to rural America.

What will it do to limit the choices we now make? If it has anything to do with making the right decision, taking that away from the patient, I will fight that. One thing that makes our current system the best in the world, besides the high quality, is the freedom the patient has to choose what they want. They can choose their doctor. They can choose their health insurance, their hospital, their pharmacy, and the services they want. Yes, the services may be unnecessary. Who knows? Who is going to make that judgment? Or some tests may be done for ease of mind. But is that decision not for a patient and a doctor? Do we still live in America? Somebody is going to make that decision.

I have a little cartoon here. There is one thing about this town; if you do not maintain your sense of humor around here, it soon goes away. What I am hearing—I think it is indicative here of the fears I am hearing about, the fears of what will happen if the Government gets involved, if patients and their doctors lose their ability to make their own decisions.

Let me read it to you. It is Doonesbury. It says:

Mmm * * * a lot of fluid here * * *
So what are we looking at?

Another person comes in:

I don't know yet. Could be a damaged anterior—
I do not know what that stuff is, but "I have a hurt knee."
Uh-hum. What's your plan?

But the second person ends up being the man's insurance agent. That is what we are looking at here. Government is already wondering about these kinds of things. That is what Montanans are telling me: They do not want a bureaucrat in Washington, DC, to make decisions for them.

You may think that some folks in the country do not know enough to make an informed decision. I think they do. They are very capable, hard-working people, trying to take care of their families. They do not like the folks inside the beltway making those decisions, and I realize the folks inside the beltway probably do not like that, but it is true.

Then there are the taxes. Taxes are taxes, whether you call them payroll contributions, revenue assessments, or whatever. It is all the same. They are taxes. I have seen a phony tax. Remember the old one: "How much did you make last year?" The next line says: "Send it in."

We may get to that point. We already took a big tax hit last year and, yes, you might say it did not hit the middle class. It did. It went a little bit deeper than we all think it did.

We live on the Canadian border. We heard some folks talk about the Canadian system, single-payer system. This comes out of the July 15 Calgary Herald. There are probably some Westerners here who probably understand what the picture is here. I will hold it up. But on that day when the Calgary stampede was on, they have a picture of a steer wrestler who is in a bit of a bind. He caught a horn in the chin. In other words, that is a plumb wreck. I thought what better thing to put across on the page than the headline: "Axe Falls on Calgary Hospitals."

Hospitals are being closed because they do not have enough money to make it to the end of the fiscal period so they closed the hospital. So you can say in the United States we have universal access but not universal coverage. They have universal coverage, but they do not have universal access.

In Montana, if you go down to the medical corridor in Billings, MT, one out of every five cars in the parking lot bears a Canadian license plate. They are not there for a social occasion, I can tell you that.

But the highlights of the story is that the Bow Valley, Holy Cross, and Grace Hospitals are to be closed, their programs are moving somewhere else. Holy Cross renovations and Bow Valley renovation plans have been canceled. Alberta's Children's Hospital remains open on the current site and continues to offer care but limited.

Of course, you can go all through this newspaper and even on the back where the unions are saying we have to have more money or we are going to close these hospitals. If you get sick, they are going to say, "Well, we didn't make it till Thursday. You've got to find another hospital to go to." All of this in this newspaper, and basically what you are looking at is a old steer wrestler and he is in a wreck, folks, and that is not funny. He catches one of those horns in the chops. I guarantee you that.

So we have a lot of folks here who want to offer their opinion on what it would do if we went to a single-payer or a big-Government bureaucracy or a Government-run plan and mandates. And they are in this bill, do not ever let anybody tell you any different because when you get to 2002, they are there. Even some of them will apply to South Dakota.

I also want to put in the RECORD "Government Health Care. Thanks Anyway, Says Libby, Montana." Libby, MT is a little town up in northwest Montana. They have had mill closings. They are completely dependent on public lands to make a living. I do not know of a tougher town in America, but they just take things. But there was a little article that came out of their newspaper up there, and I ask unanimous consent that it be printed in the RECORD because I think it deserves the attention of my colleagues who serve in the Senate.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

GOVERNMENT HEALTH CARE: THANKS ANYWAY, SAYS LIBBY, MONTANA

(By William Perry Pendley)

What were the odds that the Montana town of Libby would be hit with three catastrophic health care cases in such a short period of time?

In February 1992, Sally Sauer, 26 year old daughter of an unemployed forester, discovered she needed a heart transplant. In February 1993, 5 year old Amanda Johnson, daughter of an uninsured logging truck driver, needed heart valve surgery. Six months later, Kyle Rosling, 17 year old son of an uninsured sawyer needed heart surgery.

Libby is a tiny community of 2800 in Lincoln County where 78% of the land is owned by the U.S. Government. As a result of U.S. Forest Service timber harvest cut backs, to "protect" the grizzly bear, Libby's unemployment has been double digit for months.

Nonetheless, the people of Libby and neighboring Troy set out to save Sally, Amanda and Kyle. Through a variety of campaigns and through the generosity and hard work of the industries and individuals of northwestern Montana, the "Sally's Heart", "Hour Amanda", and "Kids for Kyle", campaigns raised more than $325,000. Today Sally can be seen jogging around town, Amanda is completely cured and Kyle is wrestling in the 152 pound class on the Libby Loggers varsity team.

What happened to Libby's Sally, Amanda and Kyle might well be cited, by the Clinton White House, as proof that America needs federal health care. Certainly Libby's experience is no less compelling than the other anecdotal evidence heard by Hillary Rodham Clinton's secret health care panel. At least that's what ABC's "Home Show" thought.

When ABC heard about Sally, Amanda and Kyle, it sent a crew to Libby to film men and women citing their ordeal as proof that America needs a federal health care plan. The film crew heard plenty about Sally, Amanda and Kyle, but the lessons the people drew from their experience surprised the folks from ABC.

Yes, Sally, Amanda and Kyle had been pretty sick. Yes, getting them well had cost a lot of money. Yes, many of the people in Libby didn't have their own health care plan. However, the people of Libby were unwilling to whine about their experience or to jump to conclusions about the state of the nation's health care and what ought to be done about it.

What the ABC crew heard was not the rhetoric of the Washington, D.C. crowd, but questions real people ask if given the chance. "What's all of that going to cost?" "Who's going to pay for it?" "Will we get to select our own doctors?" One viewpoint the ABC crew heard over and over was that the health care proposal the people had been hearing about was a very expensive program that the American people simply couldn't afford.

The ABC crew heard something else. Many of the men and women interviewed had been covered by a health care plan; that is, until environmental policy gone wild had taken their jobs. What many of them said was that if President and Mrs. Clinton wanted to do something about health care, the Clintons could get the environmentalist off the backs of the people and allow the harvesting of trees in the forests around Libby once again. Just let the mills reopen, they said. Then health care will take care of itself.

When people talk about a federal health care program, they forget about all the other things the U.S. Government can't seem to get right. The people of Libby aren't that forgetful. Perhaps it is because they know first hand how the federal government operates. Perhaps it is because they have seen what federal control means to their lives. Whatever the reason, the people of Libby, interviewed on the streets of their struggling town, have said "no" to federal health care. Having heard President Clinton's State of the Union Address and his commitment to health care in 1994, they wonder what the rest of the nation will say.

Mr. BURNS. Mr. President, I want to thank my colleague from Minnesota for the time. And as we move this through, we have great challenges. But a rush to judgment on this issue does not serve the issue or this country or its people very well.

I yield the floor.

Mr. DURENBERGER addressed the Chair.

The PRESIDING OFFICER. The Senator from Minnesota.

Mr. DURENBERGER. Mr. President, my colleague from Montana pointed out that there are two committees that deal with health care in the Senate, and he has not been fortunate enough to be on either one of them. I must say, I have had the misfortune, if you will, of being on both of them.

It also demonstrated something else to me, and that is, we do not have a health committee, as such, in the U.S. Senate. So we are working at it from a variety of other sources which makes the job very, very difficult.

I want to thank my colleague from Montana for his commitment. We have been going to breakfast together on Thursdays for 4 straight years down the Hall. He has been part of the Republican health reform task force, medical malpractice reform program, and a variety of others. I am really very appreciative of his comments.

I am reminded also of what he said about the Mitchell bill; that it took those of us who think we know something about it 4 straight days to get through the first draft of that bill and found in our efforts to try to come up with amendments, it is almost impossible to amend.

So I appreciate very much his comments, and as one who sees a lot of Canadian license plates—Ontario, in particular—in parking lots and hospital parking lots in Grand Forks, ND, Duluth, MN—a whole variety of cities. I am sure glad he told us what happened during the Calgary stampede to the hospitals in Canada. That happens in Toronto and other areas as well. It is not just in Saskatchewan.

Mr. DASCHLE addressed the Chair.

The PRESIDING OFFICER. The Senator from South Dakota.

Mr. DASCHLE. Mr. President, I listened with great interest to our dear friend from Montana. I have a profound respect for him and admiration for his great sense of humor. But I must say, I must differ with him on a number of points. I have not seen license plates on either side of the border enough to count, but I know that there are plenty of U.S. license plates on the other side of the Canadian border because that is where they get primary care, good preventive care at times. I know there are those Canadians who tell us that it is cheaper for them to fly first class to the United States and use our high technology than it is for them to buy it.

So I know there are plenty of arguments on both sides. But I think the main point that I would make is the same point I made this morning, a point the majority leader has made so eloquently on so many occasions, most recently last Sunday. And that we talk about how concerned we are, or I should say some of our colleagues talk about the concern that they have with regard to Government health care. Yet I have not yet seen a bill or an amendment to abolish Medicare. I have not seen a bill or amendment to abolish the Federal Employees Health Benefits Plan. I have not seen a bill or amendment to abolish the Capitol physician, or our opportunity to use Walter Reed or Bethesda when we need health care.

The fact of the matter is every Member of Congress uses the health care that is so criticized on the other side of the aisle so frequently every time we get sick. The President uses it, Senators use it, Members of Congress use it. There are times, of course, when our families have to use the health care provided so well in the Federal Employees Health Benefits Plan.

We talk about how extraordinary a plan it is and how we really do want to give everybody else the same opportunity to have access to good quality care that we have through the Federal Employees Health Benefits Plan. That is a Government plan. I have not seen any effort to abolish the Veterans Administration or the defense hospital system that has done such a good job.

I think we need to be clear here. Every Member of Congress benefits substantially from a Government health program and has chosen not to offer any legislation that I am aware of to abolish it. So that is point No. 1.

Point No. 2 is that it is somewhat ironic, frankly, that we talk about a Government-controlled plan when Senator MITCHELL's bill does just the opposite in providing 30 million Americans who are now under Medicaid the opportunity to buy private insurance. So we shift away from Government insurance in that case to a private plan. We want to build as much as we can on the private system. Now, ought there be some regulation? I think every Member of the Senate would agree that as we regulate the air traffic control system, the banking system, our agricultural system, our highway system, there has to be some form of a regulatory framework within which the private sector works to assure us access and confidence and cost control and all of the things we say we want.

So I would hope that as we go through this debate, we can have an honest debate, recognize the differences that exist in philosophy and position. But I would hope that we also would acknowledge that there are Government systems that work pretty well or we would not avail ourselves of them so frequently, and that, indeed, while we understand how good Government systems can be, that is not the purpose of the Mitchell bill.

ANTITRUST AND THE HEALTH SECURITY ACT

Mr. HATCH. Mr. President, we have had a very informative exchange of information today, which has revealed a number of defects in both our current health care delivery system and in attempts by the majority to remedy those problems.

One area which our discussion has not touched upon in any great detail is antitrust.

I have been dismayed that, despite a clear need for antitrust reform, as evidenced by hearings in both the Judiciary and Finance Committees, neither the Mitchell, nor the Kennedy, nor the Moynihan bills contain any antitrust relief for the myriad actors in the rapidly changing health care marketplace.

As my colleagues are aware, in an attempt to address the need for antitrust reform, last year Senator THURMOND and I introduced S. 1658, the Health Care Antitrust Improvements Act. Our colleague, Representative BILL ARCHER, introduced the companion House legislation, which served as a model for amendments adopted by the House Judiciary Committee.

Since Senator THURMOND and I introduced S. 1658, a number of provider groups have expressed concern about provisions in this legislation which they believe would afford greater protection to doctors than to other health care providers.

As we have made abundantly clear on a number of occasions, that was neither our intent nor, we believe, the effect of the legislation we drafted.

However, due to substantial and continuing apprehension about that provision, Senator THURMOND and I offered to make changes in the legislation to address those concerns.

I think it would be useful for my colleagues to be aware of those changes, and for the health care community to be aware that I continue to believe that antitrust relief is a necessary part of health care reform.

For those reasons, I am inserting in the RECORD at this point a summary of our revised legislation, which I commend to my colleagues for their serious consideration.

SUMMARY OF HATCH-THURMOND HEALTH CARE ANTITRUST IMPROVEMENTS LEGISLATION

Following is a summary of the Hatch-Thurmond Health Care Antitrust Improvements legislation, which has been revised to address concerns raised about the "Health Care Antitrust Improvements Act" as introduced last November by Senators Hatch and Thurmond (S. 1658), and by Representative Archer (H.R. 3486). The principal changes made are indicated in bullet points.

The Hatch-Thurmond legislation is intended to resolve some of the uncertainty that surrounds the application of the antitrust laws to health care activities. The purpose is to save money and improve quality in health care, not for the benefit of providers, but for the ultimate benefit of patients and those who pay the bills. Four methods of achieving greater clarity in the antitrust laws are employed:

I. SAFE HARBORS

To reduce the costs of antitrust regulation in the health care marketplace and decrease the burden of repetitive review under the certificate process, the Department of Justice is directed to develop "safe harbors." DOJ must solicit input on possible safe harbors through notice and comment procedures. The safe harbors will be defenses in all federal, state and private antitrust suits, except for injunctive relief by the DOJ or FTC in "extraordinary circumstances."

The safe harbors to be developed must cover at least the following areas:

A. Joint Purchasing of Health Care Services;

B. Small Hospital Mergers;
C. Network Formation and Operation;
D. Medical Self-Regulatory Entities;
E. Provision of Information by Providers;
F. Participation in Surveys;
G. High-Tech and Tertiary Joint Ventures;
H. Market Power Screens;
I. Joint Purchasing Arrangements; and
J. Good Faith Negotiations.

The major change is that the safe harbors are not created by statute. DOJ may add to safe harbors it establishes, and may modify or eliminate them. This allows flexibility in the safe harbors, while giving meaningful legal effect to the standards established by DOJ.

Activitiy within a safe harbor is subject to antitrust actions for injunctive relief by DOJ or FTC. This encourages providers to monitor their own conduct to ensure that it does not cause anticompetitive harm even if it is technically within a safe harbor. Additional categories for safe harbors have been added.

II. CERTIFICATES OF REVIEW

Health care providers who seek greater certainty under the antitrust laws may apply to DOJ for a certificate of review, which will be granted (if appropriate) based on a review of the facts of the case. DOJ must take into account health care concerns such as access to care in underserved areas, in addition to conducting a traditional antitrust competition analysis. Activity covered by a certificate later found to be anticompetitive is subject to injunctive relief.

Certificates of review are not automatically approved by the end of a 90 day period. Private, state and federal antitrust actions for injunctive relief are permitted to stop anticompetitive conduct covered by a certificate of review. Judicial review of DOJ decisions concerning certificates of review is limited to abuse of discretion and must be brought in the U.S. District Court for the District of Columbia. "User fees" of up to $5000 may be collected to cover costs, on a sliding scale based on size of transactions proposed.

III. NOTIFICATION

Health care providers which form joint ventures may file a notification of their activities with DOJ and in return will, if sued under the antitrust laws, receive Rule of Reason analysis (analyzing procompetitive and anticompetitive effects of conduct) and be subject to actual damages (rather than treble damages).

Notification is restricted to joint ventures, rather than any collaborative activity. Provisions "deeming" notification without written submission of required information have been eliminated. Excludes "naked" price-fixing, bid-rigging, and market allocation from notification provision, but permits showing that conduct has procompetitive aspects. Authorizes collection of user fees of up to $250 to cover costs.

IV. GUIDELINES

DOJ is directed to issue guidelines regarding legitimate collaborative activities of health care providers to further health care reform, including:

Product and geographic market definitions;

Special rules for underserved areas, such as rural or inner city markets;

Provider networks;

Community health centers;

The subject matter areas of the safe harbors listed above. Additional categories for guidelines have been added.

Mr. DASCHLE. Mr. President, my friend, the Senator from Minnesota, has kindly consented to allow us to complete our work on a couple of the housekeeping chores, and I will do that at this point.

Mr. DURENBERGER. Will my colleague yield to me just a minute?

Mr. DASCHLE. I would be happy to yield to the Senator from Minnesota.

Mr. DURENBERGER. Before we leave the subject of Government-run programs, I think it is fair to make a distinction between the Federal Employees Health Benefit Plan, which is merely an OBM or human resource run process by which each of us can buy a private health plan, and access to a private system. The only role the Government plays in there is the role of the employer, and they pay 72 percent of the premiums.

On the other hand, Medicare and Medicaid are Government-run systems, where the Government pays a specific fee for a service much like they do in Canada. And I think it is appropriate to at least make that distinction. Where, in the private health plan that President Clinton promised to all Americans, that could not be taken away from them, the Mitchell bill does not give the elderly or the disabled the opportunity to get the same kind of health care through the same system that we can.

Mr. DASCHLE. I appreciate the Senator's clarification, but I would only say that I think it fits certainly my definition of Government program when it is limited to Government employees and their families. It is run by Government employees. It is designated to be a governmentwide system specifically designed for all agencies of Government and their employees, paid for by the Federal Government as the employer.

So from that perspective it would seem to me that it would meet the definition of Government. But that is, I suppose, a matter of interpretation, and I appreciate the Senator from Minnesota making his point.

MORNING BUSINESS

Mr. DASCHLE. Mr. President, I ask unanimous consent that there now be a period of morning business with Senators permitted to speak therein for up to 3 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

IS CONGRESS IRRESPONSIBLE? YOU BE THE JUDGE ABOUT THAT

Mr. HELMS. Mr. President, before we ponder today's bad news about the Federal debt, let us have a little pop quiz: How many million dollars would you say are in a trillion dollars? And when you answer that, just remember that Congress has run up a debt exceeding 4½ trillion dollars.

To be exact, as of the close of business this past Friday, August 12, the Federal debt stood—down to the penny—at $4,645,748,084,784.22, meaning that every man, woman, and child in America owes $17,819.53, computed on a per capita basis.

Mr. President, to answer the question—how many million in a trillion—there are a million million dollars in a trillion dollars. I remind you, the Federal Government, thanks to the U.S. Congress, owes more than 4½ trillion dollars.

CURIOUSER AND CURIOUSER

Mr. DECONCINI. Mr. President, I do not necessarily believe everything I read in the paper. And I certainly do not believe everything Mr. Greenspan has to say. But the overwhelming weight of what I hear is that Mr. Greenspan and the Federal Reserve are planning on raising interest rates again.

Do not do it, Mr. Greenspan. If you are bored down there at the Fed, if a rosy economic outlook makes you blue, get out of town, take a vacation, do anything, but just do not raise those interest rates.

There seems to be general agreement that we can expect another increase in interest rates at the Fed's August 16th meeting. This fact is seen as a done deal, in spite of economic indications that it is not necessary. The August 15 edition of Business Week notes that even the Fed's own August 3 survey of regional economies points to a slowing in the economy, but acknowledges that "it is unlikely to prevent another widely expected hike in short rates by the Federal Reserve in mid-August." Why not, Mr. President? Does Mr. Greenspan like bad news so much that he wants to create more?

The Commerce Department estimates that the first quarter growth rate was 3.3 percent and the second merely 3.7 percent—substantially below the 4½ to 5 percent that Business Week asserts was widely anticipated. But clearly this isn't gloomy enough for Mr. Greenspan. Following Mr. Greenspan's logic is a little like Alice in Wonderland—it gets curiouser and curiouser.

Do America a favor, Mr. Greenspan, defy conventional wisdom, do not raise interest rates. Economic growth is good. Americans working is good. Low interest rates are good.

Alan Greenspan reminds me a little of Shakespeare's Hamlet who said "Nothing is either good or bad but thinking makes it so." Hamlet was a tragedy, do not turn the American economy into a tragedy as well, Mr. Greenspan.

VERMONT LAWYERS HELP DEVELOP RULE OF LAW IN FORMER SOVIET UNION

Mr. LEAHY. Mr. President, Vermont lawyers have been volunteering their

time and energies to help develop the rule of law in the emerging Democracies of the former Soviet Union.

They have been helping their counterparts in Russia and other democratic states learn the values of the American system of jurisprudence, lecturing, and providing videotape instruction on the conduct of jury trials and establishing the rule of law for civil disputes and criminal matters.

Many Vermonters are involved in this effort, including our esteemed Associate Justice of the Vermont Supreme Court, and my very good friend, John A. Dooley.

Mr. President, I ask that the following news report that appeared in the Times-Argus of August 10, 1994, be reproduced in its entirety in the CONGRESSIONAL RECORD so that the efforts of Justice Dooley, the Vermont Bar Foundation, and George Burrill, president of Associates in Rural Development of Burlington can be shared with the American people.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

[From the Times Argus, Aug. 10, 1994]

VERMONTERS HELP LAWYERS IN RUSSIA ESTABLISH RULE OF LAW, TRIAL BY JURY

Russian lawyers and judges will be getting legal advice from their Vermont counterparts under a contract signed Tuesday between the U.S. Agency for International Development and representatives of the Vermont Bar Foundation and a Burlington based company that specializes in third world development.

At a ceremony hosted by Sen. Patrick Leahy of Vermont, Associate Justice John A. Dooley and George Burrill, president of Associates in Rural Development of Burlington signed a $75,000 contract with AID to continue an exchange program with the Russian Province of Karelia that Vermont judges and lawyers have been pursuing on a voluntary basis since 1992.

Project Harmony, which has been part of Vermont's special relationship with Karelia since 1990, and the Vermont Bar Foundation, have created exchanges between the two countries on Vermont and U.S. Constitutional law, judicial systems and federalism, commercial law and environmental laws and regulations.

On July 26, Justice Dooley and Burril signed the first formal contract for staff services under the Freedom Support Act. The law, enacted two years age, establishes a rule of law exchange between the United States and emerging democracies in the former Soviet Union.

Nine regions of Russia now experiment with jury trials—but the first was held only last December.

The Vermont contribution to the establishment of a legal base in Karelia includes videotapes of a jury trial, lectures and detailed procedural advice on establishing the rule of law in civil disputes and criminal matters.

A delegation of Vermont legal representatives, led by former Gov. Phil Hoff, John Downs and Jan Eastman began developing a legal exchange with Karelia in 1990.

Justice Dooley, Downs, William Sessions, Mark Oetiinger, David Kelley, Eastman and the late Bishop John Marshall lectured to audiences of lawyers, government and business representatives in Russia.

A delegation of Karelian judges and Ministry of Justice staff visited Vermont in October 1993 to study the Vermont legal system. Upon their return to Karelia, the group formed a bar association similar to the Vermont model and the government began examining options to license and regulate the profession.

At ceremonies in Leahy's Agriculture Committee hearing room, the Senator praised the efforts of the Vermont Bar and Project Harmony for "helping the Russians understand the laws that govern our lives as Americans—and guiding them toward greater Democratic participation in the system."

TRIBUTE TO SHERIFF HENRY QUILLIAN EVATT, JR.

Mr. SASSER. Mr. President, today I rise to pay tribute to a shining star of Hamilton County—Sheriff Henry Quillian Evatt, Jr.—known fondly as "H.Q." He is retiring after 37 years of public service—including 22 years as chief law enforcement officer of Hamilton County.

H.Q. was born the youngest of four boys on September 9, 1929, to Hettie Lou Wallen and Henry Quillian Evatt, Sr. His father died when H.Q. was only eight, but he instilled in his sons a strong work ethic. H.Q. attended East Lake Elementary and Junior High Schools, where he was a member of championship basketball teams. After graduating from Central High School, H.Q. enlisted in the U.S. Marines and served in Camp Pendleton, CA, and the Island of Guam.

When he returned home in 1957, H.Q. was hired as the bookkeeper at the county jail. Due to the small size of the staff, he quickly took on the jobs of desk sergeant and dispatcher. H.Q. decided to further his education and completed training at the Tennessee Law Enforcement Training Academy and the Chattanooga Police Academy Law Enforcement Training School. In 1963, he became chief deputy to Sheriff Frank Newell. Following Sheriff Newell's retirement, H.Q. declared his candidacy for sheriff and was elected in September of 1968.

H.Q.'s accomplishments as sheriff are numerous. From his first term, Sheriff Evatt was committed to a high degree of competency for his officers. He instituted mandatory training for all officers, established an in-service training school for his own department, updated all recordkeeping systems for jail and crime reports, and utilized private contributions to start a fitness program for his officers.

Reacting to the diverse needs of the community, H.Q. created the first Community Relations Council and implemented a drug education program for youth. At the same time, he worked to enhance educational opportunities for inmates by providing counseling, literacy courses and a full-time chaplaincy program as part of prisoner rehabilitation.

In order to meet the increasing demands on the department, Sheriff Evatt expanded the uniformed and patrol detective divisions, started the first traffic division and expanded the major crimes division. He established a D.U.I. task force and school patrol division, and created a marine patrol division.

At a time when the crime rate is increasing and many people are frightened to leave their homes, we can all be proud of this public servant who has dedicated his life to ensuring the safety and well-being of the citizens of Hamilton County. On behalf of a grateful Nation and State, I extend appreciation to Sheriff Evatt and his family—his wife Bobbie and his children Mike Evatt, Ricky Anderson, and Sherry Swilling—for the sacrifices they have made over the years. H.Q., congratulations on a job well-done. Please accept our wishes for a healthy and fruitful retirement.

A MEETING WITH ARMENIA'S PRESIDENT

Mr. PELL. Mr. President, the Foreign Relations Committee just had a very productive meeting with the President of Armenia, Levon Ter-Petrossian. Just a few short years ago, President Ter-Petrossian was in a Moscow prison for his role in founding the Karabakh Committee, one of the first democratic movements in the Soviet Union. As one who helped to secure the Karabakh Committee's release, I was particularly gratified to welcome one of its founding members to the Foreign Relations Committee—as free, independent Armenia's head of state.

I told the President that I remember well our last meeting—in January 1992 in Yerevan—where I witnessed the terrible impact of the Azeri blockade of Armenia and the remaining effects from the devastating 1988 earthquake. I am very much impressed with President Ter-Petrossian and the notable progress Armenia had made in the face of such difficult circumstances.

During our discussion, the President brought us up to date on the ongoing conflict over Nagorno-Karabakh and the severe economic toll it is taking on the entire region. I very much welcome the news that the parties to the conflict have agreed to a formal cease-fire, and I hope that progress can be made on achieving a lasting peace.

Currently, two competing plans—one put forth by Russia and the other by the Conference on Security and Cooperation in Europe [CSCE]—are on the table. A unified CSCE-Russian approach might prove to be the best strategy. President Ter-Petrossian acknowledged that U.S. diplomatic involvement is key to this process and I would encourage the administration to heed President Ter-Petrossian's call for greater U.S. engagement.

On a related matter, I am pleased that the State Department has tapped Joe Presel, who I might add is a Rhode Islander, to be the Department's Coordinator for Regional Affairs in the New Independent States. His portfolio includes Nagorno-Karabakh, but that is just one of many issues that he must address. I also do hope that the administration will appoint a special representative to the negotiations on Nagorno-Karabakh. That position has been vacant since Ambassador Maresca retired this spring. Since that time, there has been a great deal of movement on the diplomatic front. I believe that in appointing a new representative to deal exclusively with the Nagorno-Karabakh issue, we can greatly contribute to the process of finding a lasting peace in the region.

ALLEGATIONS AGAINST A U.S. SENATOR

Mrs. FEINSTEIN. Mr. President, allegations have been made against me in my role as a United States Senator.

One of my greatest joys is to give young professionals a chance early in their career so they can become top notch, skilled professionals. Paul McDonald is just one of dozens of recent college graduates I have hired with the hope that they will learn a great deal about the Senate and serving constituents. It saddens me greatly that Paul, who chose to leave my office, has made charges against this office that are entirely untrue and false. There is not one iota of truth to his charges.

I take any charges of racial or sexual harassment very seriously. In no way did this office try to prevent Paul McDonald from pursuing his case. I have no way of knowing if his charges against Princeton and the U.S. Department of Education are valid, nor is it my place to make that determination. I know that Paul has followed a long course of legal action against Princeton. The truth is that my office never stood in his way.

Paul was not discharged from this office. He was not asked to stop pursuing his complaint of racial discrimination against Princeton and the U.S. Department of Education. He was only asked to not use office time to pursue his complaint and to not make it seem that his communication was connected to the official functions of the Senate office.

Paul joined my staff in September 1993. He competed in an application process and was selected among many other applicants for the job of legislative correspondent.

In December, Paul wrote to every member of the Senate Judiciary Committee, on which I serve, asking for an investigation into charges of racial discrimination he had made against Princeton University and the U.S. Department of Education. In his correspondence, Paul included his business card and asked members to contact him at my office.

This left the erroneous impression with my colleagues on the Judiciary Committee that this correspondence was officially connected to my office. In fact, my legislative director, Susy Elfving, received calls from the counsels of other members of the Judiciary Committee to ask if this was an official communication from my office. My staff said that clearly it was not official and that we learned about this at the same time as the other offices.

After my senior staff brought this fact up to Paul, he agreed to write a letter to each member correcting this impression. In addition, he agreed that if he chose to write similar letters in the future to Members of the Senate that he would simply notify the Senator that the communication was independent of the office.

Three weeks later, on January 25, Paul again wrote each Senator on the Judiciary Committee. In this letter, he called a response from Senator SPECTER to the earlier letter "racist." Paul threatened to hold a news conference during Black History Month in February and publicly expose the complaint if the Judiciary Committee did not respond properly. Just a few weeks earlier, Paul had agreed to attach to his letter a note explaining that his communication had no connection to my office. He failed to do so. This failure created the impression that my office had somehow condoned the communication.

After the second letter was sent to my colleagues, we simply reiterated our view that Paul not connect his complaint to this office and that he should not pursue it during office hours when he had other responsibilities.

On February 10, Paul notified us of his personal decision to leave this office and began looking for another job. He asked if he could stay on staff while he looked for a job. Three-and-one-half months later, on May 27, he voluntarily resigned to take another position on Capitol Hill.

I would like to submit the following documents for the RECORD to provide background on this matter.

January 4, 1994

To: Paul McDonald, Legislative Correspondent.

From: Michael McGill, Chief of Staff, Susy Elfving, Legislative Director.

Subject: Agreement to revise personal letter of 12/29/93.

Per our discussion of this morning, you agreed to personally retrieve all originals of the letter dated December 29, 1993, which you directed to Members of the Judiciary Committee and their staff. You will revise these letters to delete any reference to your employment by this office, including the name of your employer, your office address and phone number, so there is no implication that the issue which you are pursuing as a private citizen has been officially sanctioned by this office.

Since your employer is a Member of the Judiciary Committee, you further agreed that the copy of your correspondence that you direct to her will include a cover memo from you to her explaining that you are pursuing this action independent of your employment by this office and that you are not informing anyone involved in the process of your employment in this office.

Upon the successful completion of these actions, we agree that this entire affair will not be treated as a negative item in your personnel file. Rather, it represents a well intentioned but incorrect assumption on your part that such an identification would be useful merely for the purposes of communication between you and the addressees of your letter, and would in no way imply any sort of official sanction or support by this office.

We appreciate your positive response to this situation.

MICHAEL S. MCGILL,
Chief of Staff.
SUSY ELFVING,
Legislative Director.

ALEXANDRIA, VA,
January 7, 1994.

Sent to all Judiciary Committee Counsels:

Attached is a letter from my father and a revision of the first page of my December 29, 1993 letter requesting a meeting with the Committee on the Judiciary members and their counsel to discuss my family's call for a Committee investigation of our complaints of racial discrimination, harassment and bias against Princeton University and the U.S. Department of Education. The first page has been revised to delete the reference to my employment by Senator Dianne Feinstein in order to emphasize that my request is independent of my employment. The reference to my employment was informational and for the purpose of identifying how I may be contacted during working hours to discuss this request. I have made this request on behalf of my family and as a private citizen. Questions should be addressed either to my father, Walter E. McDonald, or to me. My father can be reached at these phone numbers: Home: (713) 265-2056, Work: (713) 656-6334.

The first page has also been revised to include Ruth Simmons, Vice Provost of Princeton University, in the list of administrators and trustees of Princeton University who supported or participated in acts of racial discrimination and harassment against me.

Please return to me the original first page to confirm receipt of this revision. I have enclosed a self-addressed, stamped envelope for your convenience.

PAUL MCDONALD.

ALEXANDRIA, VA,
December 29, 1993.

Hon. DIANNE FEINSTEIN,
Counsel,
Hart Senate Office Building.

I am requesting a meeting with Committee on the Judiciary members and their counsel to discuss my family's call for a Committee investigation of our complaints of racial discrimination, harassment and bias against Princeton University and the U.S. Department of Education. My request has been delivered to Chairman Joseph Biden and the Chief Counsel Cynthia Hogan; this letter is being delivered to each member of the Committee. Our complaints are based on:

Princeton University administrators' racial discrimination against and harassment of me, an African-American male student

leader with the support and participation of: Harold Shapiro, President of Princeton University; Hugo Sonnenschein, then Provost of Princeton University, now President of the University of Chicago; Ruth Simmons, Vice Provost of Princeton University; R.H. Rawson, Chairman of the Board of Trustees; Senator John Danforth, Member of the Board of Trustees; Hodding Carter, Member of the Board of Trustees.

U.S. Department of Education's racial discrimination and bias against my family in repeated refusal to investigate discrimination complaints against Princeton University and mistreatment of my family with the support and participation of: Richard Riley, Secretary of the U.S. Department of Education; Norma Cantú, Assistant Secretary for Civil Rights, U.S. Department of Education; Paula Kuebler, Regional Civil Rights Director, U.S. Department of Education.

I am an African-American male, recent graduate of Princeton University and former President of the Princeton University Undergraduate Student Government (president of the student body). My accomplishments at Princeton University while I was being discriminated against and harassed by university administrators are described in my resume and a Princeton Alumni Weekly article which are enclosed. I am appealing to the Judiciary Committee because my family has made every attempt to resolve my complaints against Princeton University with the U.S. Department of Education. In our pursuit of equal justice and protection under Title VI of the Civil Rights Act of 1964, we have been misled, lied to, disrespected, patronized, and summarily dismissed by Office for Civil Rights Region II Director Paula Kuebler, Assistant Secretary for Civil Rights Norma V. Cantú, and Secretary Richard Riley. Each has demonstrated racial discrimination and bias against me and my family in their refusal to investigate my complaints against Princeton University's highest-ranking administrators.

My complaints against Princeton University administrators are serious; this is not just my family's belief.

In his January 15, 1993 letter to me, R.H. Rawson, Chairman of the Princeton Board of Trustees wrote, "Your allegations are serious and need to be addressed forthrightly and promptly. * * *"

In her May 2, 1993 letter to my father (attached at end of this letter), Senator Carol Moseley-Braun wrote, "The problem of discrimination in higher education is of great concern to me. * * * The allegations you raise * * * are very serious."

My complaints against Princeton University administrators address discrimination and harassment during my last four semesters at Princeton. The stress and frustration of fighting this racism had its toll. I had abnormal fatigue and migraine headaches that were diagnosed after my junior year in the summer of 1992; I had to take medication for the migraines during my senior year. I also had periods of depression and was often unable to focus or concentrate on academics because of the persistent and isolating nature of harassment I experienced. I had considered withdrawing from the university before my father made his first of two trips to Princeton to remove me from campus so that I could concentrate and complete assignments without harassment. Before the harassment began I had maintained a 3.6 grade point average while chairing the Undergraduate Student Government committee on undergraduate life, and I had been nominated for the Harry S. Truman Scholarship for which I later became a national finalist. The harassment and discrimination caused significant drops in my grades and effectively denied me opportunities for academic honors and graduate scholarships, influencing my decision to postpone law school studies. In my last semester, administrators placed me on disciplinary probation with a threat to expel me after I initially filed a complaint against them with the U.S. Department of Education Office for Civil Rights Region II and mailed information to fellow minority students advising them to do the same if they had complaints against representatives of the university.

That my complaints were found without racial discrimination or harassment by Office for Civil Rights Region II Director Paula Kuebler, Assistant Secretary for Civil Rights Norma Contú, and Secretary Richard Riley without investigation suggests they are more interested in closing my case against Princeton University than in enforcing the law. It is therefore my family's position that the U.S. Department of Education must not be involved in any forthcoming investigation or adjudication of my complaints against Princeton University. With this letter, I am filing racial discrimination and bias complaints against Paula Kuebler, Norma Cantú and Richard Riley for their actions as representatives of the U.S. Department of Education; it is my family's hope that their actions are not indicative of a general insensitivity to and condoning of racial discrimination and harassment of African-American males on the part of public officials who are charged with protecting our civil rights. To this point, my family has found that there are few advocates for young African-American males who commit themselves to excellence and demand equal justice and respect. It appears the only young African-American males whom public officials are concerned about are those who are incarcerated.

Proper and thorough investigation of my complaints against Princeton University is important in the struggle for equal protection and justice for African-American students on predominantly white college campuses across the nation. The racism I experienced on the Princeton University campus is indicative of the 'new age' racism confronting African-American students. The 'new age' racists on college campuses are administrators and faculty who use their positions of authority in the university community to demean African-Americans, treating us as if we have no reason to expect the same attention, treatment and respect white students receive and seeking to confine us to subordinate roles they have set aside for us. For African-Americans to challenge these administrators or faculty members instead of accepting or tolerating mistreatment is unacceptable. Their response is seldom to call us 'nigger'; calling us 'nigger' is often rejected in their circles as 'unsophisticated' and, for the purposes of punishing us for standing up to them, is often not considered damaging enough. Instead their response is to use their authority to undermine our academics and activities, intending to dismantle us from the inside as our frustration and feelings of isolation increase with the realization that in this environment they determine what is right and wrong and answer to no one. Some students transfer from one college to another. Some students take time off from college. Some students dropout and do not complete their degrees. All African-American students that have experienced this 'new age' racism are denied their potential—the grades, opportunities, experiences, and peace of mind they would and should have had.

The following are brief accounts of my experiences. More information is available upon request.

PRINCETON UNIVERSITY

Princeton University's highest-ranking administrators demeaned me as a person, stigmatizing me as an African-American male representing a threat to white females and stigmatizing my parents as "rude and inappropriate" when they challenged administrators' mistreatment of me. They demeaned me as a student, stereotyping me as an irresponsible and underqualified African-American student fortunate to attend Princeton in communications to professors, threatening to rescind the university's sponsorship of a colleague's nomination of me for the Harry S. Truman Scholarship (I became a national finalist for the scholarship) and causing a significant drop in grades from the psychological stress associated with their actions against me. They demeaned me as a leader, refusing to accept me as the legitimate and elected president of the student body and subverting my agenda at the behest of a white female student who held a lower position in the student government. Again, I ask you to look at my resume. Had I been white, administrators would have heralded me instead of harassing me; they would have lifted me up instead of trying to string me up.

Enclosed are complaints I filed in the Office of the Provost at Princeton University and the U.S. Department of Education Region II Office for Civil Rights. These complaints describe specific acts of racial discrimination and harassment committed against me by: Thomas Wright, Vice President and General Counsel; Ruth Simmons, Vice Provost; Nancy Weiss Malkiel, Dean of the College; Diane Balestri, Assistant Dean of the College; Eugene Lowe, Dean of Students; Joyce Clark, Associate Dean of Students; Kathleen Deignan, Associate Dean of Students; Sandy Silverman, Assistant Dean of Students; Michael Rodriguez, Director of the Third World Center.

These complaints also describe racist actions taken against me with the assistance or approval of administrators by Jennifer Weller-Polley '93, a white female student, and the student editors of The Daily Princetonian campus newspaper. The academic department I was enrolled in, the Woodrow Wilson School of Public and International Affairs, also discriminated against me in assigning me to a public policy conference.

President Harold Shapiro is implicated in these complaints because the McDonald family appealed to him, in person and in letters, to protect me from the racial discrimination and harassment of the administrators listed above. From our communications, Shapiro understood the injurious effects the actions of administrators had on me (academic, physical and psychological) but did nothing to stop the harassment. I appealed to Chairman of the Princeton University Board of Trustees Robert H. Rawson and Trustees Senator John Danforth and journalist W. Hodding Carter III asking that the Board of Trustees intervene since the highest-ranking administrators were involved. In his response Rawson acknowledged my charges were "serious and need to be addressed forthrightly and promptly by the University" but insisted the administration could handle my charges despite the fact top administrators had either committed, supported, or condoned the racist actions that I was challenging. Through their silence on the matter after I had sent copies of my complaint to them, the entire membership of the Board of

Trustees also indicated that their interest was not in addressing racism on campus but instead in covering up campus racism.

Princeton University's indifference and sometime hostility to student concerns of racial discrimination and harassment in the past and present (as I have documented in the enclosed race record and my open letters to the university community) and its failure to adopt a racial harassment policy despite repeated attempts by students to establish a policy as recently as this past March make it clear that minority students on Princeton's campus have no rights which administrators, faculty or students have to respect. The fact that no minority student has been successful in challenging administrators has permitted them to become more resistant and arrogant in their racism over the years. Minority students have no recourse on Princeton University's campus.

Administrators placed me on disciplinary probation with a threat to expel me after I had filed a complaint against the university with the U.S. Department of Education Office for Civil Rights and mailed information to fellow minority students advising them to do the same if they were unsatisfied with the university's handling of their racial discrimination and harassment complaints (see enclosed New York Times and Associated Press articles). They isolated me on campus with the assistance of student editors of the Daily Princetonian through their attempts to assassinate my character in campus newspaper articles. Vice Provost Ruth Simmons, an African-American female who was supposed to be an advocate for minority student concerns, took every opportunity to make false accusations about me in articles in an effort to discredit me. Frankly, she considered my statements on the university's lack of commitment on racial issues a threat to her career plans; the Provost Hugo Sonnenschein and announced he would be leaving to become president of the University of Chicago, and Simmons had been mentioned for the position because of her supposed efforts to improve race relations. The administration and editors of the campus newspaper made repeated personal attacks on my character, but one instance particularly stands out from others. The editor-and-chief of the newspaper decided to print a negative article about me written by the son of an administrator against whom I had filed a racial discrimination complaint. The editor printed this negative article after I had written a letter to President Harold Shapiro, Vice Provost Ruth Simmons, and her asking that the article not be run because of the personal bias of the reporter. The editor then refused to print letters written in support of me after running the negative article; two students even contacted me to tell me their letters of support had been refused by the editorial board.

Dean of Students Eugene Y. Lowe admitted to my father that there were, in Lowe's words, "several administrators" who were "upset" with me during my father's trip to Princeton in March 1993. Lowe's comment was remarkable—not just because it was so candid a statement of administrator's biases against me, but also because he even spoke with my father. After my father had arrived for a meeting scheduled in the previous fall semester with an Associate Provost to discuss my family's concerns about racial discrimination against me, he had been handed a letter informing him that Vice President and General Counsel Thomas Wright had "directed university administrators not to deal with you [my father] either by telephone, or in person, or in writing" and that the meeting had been cancelled. My father wrote a letter to Wright and President Harold Shapiro indicating that he had not been notified of the cancellation before he had arrived for the meeting. Wright refused to apologize or offer to reimburse my father for the expenses he incurred making the trip from Houston to Princeton. Furthermore, Wright wrote, "I regret that you believe a number of University administrators have treated you and your son unfairly on the basis of race. In light of the way you make these charges, I do not see any productive means of responding to them."

U.S. DEPARTMENT OF EDUCATION OFFICE FOR CIVIL RIGHTS

After the Princeton University Board of Trustees had failed to intervene, I filed racial discrimination and harassment complaints against Princeton administrators at the U.S. Department of Education Region II Office for Civil Rights (OCR) in New York City. I thought I had found an impartial agent that had authority by law (Title VI of the 1964 Civil Rights Act) to both adjudicate the complaints and impose sanctions upon those found to have discriminated against me. But OCR Region II demonstrated a lack of will and commitment to confronting racial discrimination. More importantly OCR officials in their insensitive questioning of whether the discrimination and harassment I had experienced was based on my race, their reluctance to either investigate complaints in a timely fashion (by their own official timelines) or investigate the most serious complaints at all, and their disrespectful treatment of my family in their communications to us have proven they are not qualified to investigate 'new age' racism and are in fact racist themselves.

Consider that in OCR's Annual Report to Congress: Fiscal year 1991 it is reported that their offices receive few if any alleged racial discrimination or harassment complaints brought by students against universities or colleges based on direct actions employees or representatives of the institution took against the complainant.

Seventy-nine percent of the complaints received in FY 1991 alleged discrimination in the delivery of services, while most of the remainder alleged discrimination in employment. As in previous years, nearly two-thirds of all complaints alleged discrimination on the basis of handicap.

Only 17 percent of complaints alleged discrimination on the basis of race. This is not because racism has declined on campuses across the nation; according to most reports, there has been an increase of racist incidents on campuses. The small percentage of complaints alleging racial discrimination can be attributed to the general lack of information about the U.S. Department of Education Office for Civil Rights and its purpose. Simply put, most minority students (it is possible 90 percent or more) do not know OCR exists because OCR has made no attempt to increase awareness among minority students. It appears that African-Americans whose grandparents and parents gave and risked the most for civil rights are among the last to be protected by OCR's annual $48 million efforts to insure compliance of civil rights laws. Yet members of Congress certainly assume, if for no other reason than the title "Office for Civil Rights," that OCR champions equal justice and respect for African-Americans. My experience proves otherwise and is strong argument that OCR should be investigated by Congress for condoning the racism the office is supposed to fight.

My father and I personally delivered a 30 page racial discrimination and harassment complaint to OCR Region II in New York City on January 21. This complaint, which I had previously filed in the Office of the Provost at Princeton University, fully detailed the racial discrimination and harassment that I had experienced at Princeton University in the previous semesters. Eddie Pinkney of OCR reviewed this 30 page complaint and told my father and me that it was too lengthy and detailed for purposes of filing a complaint at OCR. Pinkney did not indicate that the 30 page complaint lacked any information needed to initiate an investigation nor did he question the validity of my charges of racial discrimination. He did suggest I fill in one of the standard OCR discrimination complaint forms while in the office and submit this form instead of the 30 page complaint. The official discrimination complaint form has little space for detailed description of a complaint; Pinkney said simple statements to the effect "I was discriminated by * * *" for each instance of discrimination would be enough for filing a complaint. He also instructed me to request an extension of the normal six month OCR filing period in a letter to Paula Kuebler, Regional Director of OCR Region II.

I submitted a complaint and request for a waiver of the 6 month limit normally applied to complaints to Paula Kuebler, Regional Director of OCR Region II, on January 26 (enclosed). In a letter to me dated February 12 (enclosed), OCR Region II stated "We have carefully reviewed your complaint and determined that you have provided this Office with insufficient information concerning most of your allegations to initiate an investigation." OCR also stated "it will be necessary for you to request a waiver of the timeliness requirement [180 calendar days of the last act of alleged discriminatory conduct]." OCR listed nine requests for information.

A critique of OCR's requests for more information (enclosed) in light of the details in the complaint filed on January 26 reveals that OCR did not "carefully review" my complaint and that their claim of "insufficient information" had no merit. OCR's insincere response to my complaint intended to either postpone investigation or discourage me from further pursuing the entire complaint in their office. OCR hoped to appease me in stating that the complaint against instructors for refusal to grant class assignment extensions was complete; this complaint in fact had less detail than the other complaints against top Princeton University administrators, but appears to be the easiest complaint to resolve because at first glance there seems to be a possible compromise or conciliation, i.e. the granting of extensions and changing of grades. But the complaints against administrators do not suggest means of conciliation; these complaints require confrontation and strict sanctions to resolve. I am convinced that OCR never intended to investigate my complaints against Princeton University administrators.

I did not respond to OCR's requests for more information; as stated and demonstrated in the enclosed critique of OCR's requests, my original complaint was in fact complete. I was frustrated by OCR's insensitivity and incompetence and had more or less abandoned hope. University administrators had begun to retaliate against me for making minority students aware of the option of filing discrimination complaints against the university with OCR. In order to

graduate in June, I had to research and write an 80 page thesis by April 5. I did not have the time or energy to conduct the investigation for OCR, which is what OCR seemed to expect me to do in their repeated requests for "factual information which would support your feeling that these actions were discriminatory because other individuals in similar circumstances were treated in a more favorable manner than yourself." The determination of discrimination—through the gathering of factual information from all parties and through considering both the treatment of others in similar circumstances and the potential that the circumstances affecting the complainant are unique—is OCR's job, not the complainants. This is so if for no other reason than the fact that the accused institution has no incentive to cooperate with the complainant and provide him or her factual information supporting his or her feeling that the institution's actions were discriminatory but must cooperate with OCR because OCR has authority to enforce Title VI of the Civil Rights Act of 1964.

My father and I called OCR and asked to speak with Regional Director Paula Kuebler, but she refused to discuss the original complaint with us. My father filed a retaliation complaint on my behalf on April 12 against Princeton University administrators for their placing me on disciplinary probation after I had informed minority students of their right to file discrimination and harassment complaints against the university with OCR; this complaint was sent with a cover letter to Secretary of Education Richard Riley and Attorney General Janet Reno (enclosed) requesting that they take action from their offices because of the incompetence and insensitivity demonstrated by OCR Region II. When my father called the Department of Education to inquire about the retaliation complaint, he was transferred to the office of Jeanette Lim, then Acting Assistant Secretary for Civil Rights. Lim's assistant said that she had prepared a letter to be sent to my father. My father asked if the letter could be faxed to him, to which Lim's assistant replied, "We don't fax letters and don't call here again." My father then faxed letters to Secretary Riley and Attorney General Reno requesting meetings to discuss all my complaints (the entire original complaint and the retaliation complaint) and OCR's mistreatment of us. On June 3, Norma Cantú, who had recently been appointed Assistant Secretary for Civil Rights, responded to my father's request to meet with Secretary Riley stating that "communicating with increasingly higher level Government officials will not affect the OCR regional offices' careful, deliberate evaluation * * *" She told us to direct questions about all complaints to OCR Region II despite the fact we had indicated reservations about the regional office's handling of the original complaints. OCR agreed to investigate the retaliation complaint after Senator Carol Moseley-Braun, whom my father had copied in his letter attached to the retaliation complaint, wrote Secretary of Education Riley in support of our request for a full investigation of all my complaints. But in her response to Senator Moseley-Braun, Cantú purposely misled the Senator, stating that "my staff have looked into your constituent's situation and advised me that Mr. McDonald's complaints are under investigation." In fact, the majority of the original complaints addressing the most damaging actions against me were still not being investigated.

When we finally spoke with Regional Director Paula Kuebler, we indicated that we wanted to appeal OCR Region II's determination that insufficient information had been provided on the complaints against Princeton administrators and OCR Region II's subsequent decision not to investigate these complaints; she said there was no appeal process and accused us of "asking for special treatment." On August 3, I wrote a letter to Norma Cantú appealing OCR Region II's decision not to investigate my original racial discrimination complaints against Princeton administrators; I included the critique of OCR's request for more information that is enclosed here. I requested that Cantú appoint a special counsel to investigate all my complaints and the mishandling of the original complaint by OCR Region II. In Cantú's response (signed by Jeanette Lim), she once again lied about the status of the original complaints against university administrators stating that the "regional office is currently investigating your complaint" in response to my specific inquiry about the original complaints against administrators. She again told us to direct further questions to OCR Region II despite the fact I had specifically called for an investigation of that office in my appeal. OCR Region II should have been disqualified from investigating or adjudicating any of my complaints based on their mishandling of complaints and mistreatment of me and my father. I delivered a letter to Cantú's office on August 24 requesting a meeting with her. Her chief of staff responded in a letter that Cantú would not meet with me and that OCR was "sorry if we have been unable to resolve this matter to your satisfaction.

I did receive an OCR letter of finding dated October 21 from OCR Region II Director Paula Kuebler. This letter of finding was considerably late in its issuance by OCR's official timelines for complaint decisions. The letter of finding addressed the complaint I had filed against two professors for denying me extensions on class assignments that conflicted with my attempts to resolve my racial discrimination complaints with the university. OCR Region II found the professors innocent of the charges I filed. My critique of the OCR letter of finding is included in my December 29 letter to Senator Edward Kennedy. This letter to Senator Kennedy also addresses a December 10 letter Cantú sent to him in response to his November 9 request for her report on the status of the appeal of OCR Region II that I had filed. These letters are all in the last section of the enclosures binder. I have still heard nothing from OCR on the retaliation complaint. The official deadline for a decision on the retaliation complaint has long passed. The fact that Cantú does not refer to it in her correspondence to Senator Kennedy suggests that OCR does not intend to investigate the retaliation complaint even though it was deemed complete and given a case number.

New age racists like the Princeton University administrators named in my discrimination and harassment complaints hold African-American students captive on college campuses. The university community is their plantation—and on this plantation African-American students have no rights these administrators, or faculty and white students, have to respect. These administrators do whatever they want to whenever they want to because they believe that African-American students have no recourse. Unfortunately, my experience with the U.S. Department of Education Office for Civil Rights supports this belief. It appears no one is willing to stand with young African-Americans who are committed to excellence and demand respect, equal justice, and equal protection under the law.

If you have any questions or need more information, please do not hesitate to contact me. I have accumulated extensive documentation, including letters to and from individuals involved in my complaints, in support of my claims. My family and I thank you for your time and consideration. We look forward to hearing from you.

Sincerely,

PAUL L. MCDONALD.

January 25, 1994.

Hon. DIANNE FEINSTEIN,
Counsel,
Hart Senate Office Building.

Attached is a January 12, 1994 letter Senator Arlen Specter sent to me regarding my December 29, 1993 request for a meeting with Committee on the Judiciary members and counsel to discuss my family's call for a Committee investigation of our complaints of racial discrimination, harassment and bias against Princeton University and the U.S. Department of Education. This letter in response is being delivered to each member of the Committee.

It is my family's hope that Senator Specter's response is not an indication of the Committee's position as we consider his response racist in its condoning of the U.S. Department of Education Office for Civil Rights' (OCR) actions to deny me due process and equal protection. We consider Senator Specter's response to be hostile to the plight of African-American students on predominantly white campuses, which I described in my December 29, 1993 letter to you as the 'new racism.' It is apparent Senator Specter is comfortable with assuming this public posture; as we have not received a response from the Committee on our request, it remains to be seen if the membership is also.

In his statement that my "administrative claim has been concluded" because of "[my] failure to file an * * * appeal within the time provided by law," Senator Specter conveniently chooses to ignore both my complaints against the U.S. Department of Education in my December 29 letter to the Committee membership and my critique of the Office for Civil Rights' findings in my December 29 letter to Senator Edward Kennedy enclosed with the materials sent to the Committee membership. In his attempt to clean his hands of the matter, however, he betrays his own reasoning. Senator Specter states, "The allegations you make regarding Princeton University * * * are quite serious." (Senator Carol Moseley-Braun had also stated that the "allegations you raise * * * are very serious" in her May 2, 1993 letter to my father attached to the December 29 letter to you.) But Senator Specter has concluded that my complaints are "serious" based on the same information that the U.S. Department of Education determined was insufficient to warrant investigation. In effect, Senator Specter acknowledges that my family has a complaint against the U.S. Department of Education for denying us due process. It is our complaint that the U.S. Department of Education has been more interested in closing our case against Princeton University than in enforcing the law. There is no other explanation for the U.S. Department of Education's decision not to investigate complaints two members of the Senate Committee on the Judiciary have characterized as "serious."

In my December 29 letters to the Committee membership, I stated that I had written

to Assistant Secretary for Civil Rights Norma Cantú on August 3, 1993 to appeal OCR Region II's decision not to investigate my complaints. I critiqued OCR Region II's request for more information and maintained through point-by-point analysis that sufficient information had been provided in the original complaint I sent to OCR to initiate an investigation. OCR Region II had "administratively closed" the majority of the original complaint based on its reasoning that I had failed to provide sufficient information by a later deadline, but if enough information had in fact been provided initially as I maintain, the deadline is moot. I remind the Committee that Senators Carol Moseley-Braun and Arlen Specter characterized my complaints as "serious" based on the same information that the U.S. Department of Education determined was insufficient to warrant investigation. I also remind you that OCR Region II after "carefully reviewing" my original complaint had informed me in their February 12, 1993 letter that it would "be necessary for [me] to request a waiver of the timeliness requirement [180 calendar days of the last act of alleged discriminatory conduct]" and address this request to Regional Director Paula Kuebler. I had made this request in the third sentence of my January 26, 1993 letter to Paula Kuebler included with my original complaint. (The letters and critiques referred to here were enclosed with the materials sent to the Committee membership with my December 29 letter.)

Although the Office for Civil Rights has issued a letter of finding on my complaints against German professors (Case. No. 02-93-2051), i.e. "administratively closed" this case, OCR has not issued a letter of finding on the retaliation complaint my father filed against Princeton University administrators for their placing me on disciplinary probation after I had informed minority students of their right to file complaints against the university with the Office for Civil Rights. This retaliation complaint (Case No. 02-93-2092) has not been closed by any official regulations. OCR simply does not intend to investigate this complaint. It is incredible that Senator Specter could ignore this pending case, and it further suggests that he has no interest in insuring due process or equal protection for African-Americans.

In his closing, Senator Specter "question[s] the propriety of Judiciary Committee review over the issues [I] present." I came to this Committee because my family has been discriminated against by a federal agency responsible for enforcing civil rights laws. Senator Specter is suggesting that those responsible for enforcing the law may not be held accountable when breaking the law and, furthermore, that law enforcement officials may adjudicate and subsequently "administratively close" cases in which they have participated in the breaking of laws in order to escape appeals, scrutiny, and sanctions. Must there be an abuse of force on the part of the police before the Judiciary decides it has propriety over the issues? It appears that although Senator Specter has admitted that my complaints are serious, he has no moral qualms about condoning the U.S. Department of Education's decision to ignore them. My family and I are convinced he has not taken me seriously because I am an African-American male. If I were a woman alleging sexual harassment, the public officials with whom my family has dealt would have shown more sensitivity and concern. It seems the only African-American males whom public officials are concerned about are those of us who are incarcerated.

My family and I remain hopeful that Senator Specter's feelings are not shared by the Committee membership. We would appreciate a response from the Committee on our request by Wednesday, February 9 as we are now making preparations to publicly expose our complaints and experiences during Black History Month if it is necessary to continue our pursuit of equal justice. We have been fighting for more than two years now. We have not come this far to turn back.

Sincerely,

PAUL L. MCDONALD.
WALTER E. MCDONALD.

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Mr. Thomas, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States submitting sundry nominations which were referred to the Committee on Environment and Public Works.

(The nominations received today are printed at the end of the Senate proceedings.)

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, which were referred as indicated:

EC-3208. A communication from the Principal Deputy Under Secretary of Defense, transmitting, pursuant to law, the Selected Acquisition Reports for the quarter ending June 30, 1994; to the Committee on Armed Services.

EC-3209. A communication from the Chairman and President of the Export-Import Bank of the United States, transmitting, pursuant to law, a report with respect to a transaction involving U.S. exports to the People's Republic of China; to the Committee on Banking, Housing and Urban Affairs.

EC-3210. A communication from the Secretary of Transportation, transmitting, a draft of proposed legislation to reduce the economic burden on United States-flagged merchant vessels by streamlining certain regulatory requirements, by expanding the delegation of the performance of marine safety functions to third parties, and by broadening the Coast Guard's marine safety authority to accommodate these changes, and for other purposes; to the Committee on Commerce, Science, and Transportation.

EC-3211. A communication from the Secretary of Energy, transmitting, pursuant to law, a notice of delay in the submission of a report relative to energy management and conservation programs; to the Committee on Energy and Natural Resources.

EC-3212. A communication from the Deputy Associate Director for Compliance, Department of Interior, transmitting, pursuant to law, a report relative to refunds of offshore lease revenues where a refund or recoupment is appropriate; to the Committee on Energy and Natural Resources.

EC-3213. A communication from the Assistant Secretary of State for Legislative Affairs, transmitting, pursuant to law, a report relative to International Labor Organization Convention No. 174 and Recommendation No. 181; to the Committee on Foreign Relations.

EC-3214. A communication from the Assistant Legal Adviser for Treaty Affairs, Department of State, transmitting, pursuant to law, a report relative to international agreements other than treaties entered into by the United States within the sixty day period prior to August 11, 1994; to the Committee on Foreign Relations.

EC-3215. A communication from the Assistant Secretary of State, Legislative Affairs, transmitting, pursuant to law, a report relative to the authorized furnishing of defense articles to the Dominican Republic; to the Committee on Foreign Relations.

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second time by unanimous consent, and referred as indicated:

By Mr. GRAHAM:

S. 2388. A bill to authorize the Secretary of Transportation to issue certificates of documentation with appropriate endorsement for employment in coastwise trade for each of two vessels named *Gallant Lady*, subject to certain conditions, and for other purposes; to the Committee on Commerce, Science, and Transportation.

By Mr. BRYAN (for himself and Mr. GRAHAM):

S. 2389. A bill to reform habeas corpus procedures; to the Committee on the Judiciary.

By Mr. PRESSLER:

S. 2390. A bill entitled the "Mentorship for American Indian Small Enterprise Act"; to the Committee on Indian Affairs.

By Mr. SIMON (for himself, Mr. PRYOR, Mr. DECONCINI, Mr. METZENBAUM, and Mr. REID):

S. 2391. A bill to repeal the prohibitions against political recommendations relating to Federal employment, and for other purposes; to the Committee on Governmental Affairs.

By Mr. JOHNSTON (by request):

S.J. Res. 217. A joint resolution to approve the location of a World War II Memorial; to the Committee on Energy and Natural Resources.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. FORD (for himself and Mr. DOLE):

S. Res. 249. A resolution to authorize testimony by an employee of the Senate and to authorize representation by the Senate Legal Counsel; considered and agreed to.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. GRAHAM:

S. 2388. A bill to authorize the Secretary of Transportation to issue certificates of documentation with appropriate endorsement for employment in

coastwise trade for each of two vessels named *Gallant Lady*, subject to certain conditions, and for other purposes; to the Committee on Commerce, Science, and Transportation.

DOCUMENTATION FOR THE VESSELS "GALLANT LADY"

Mr. GRAHAM. Mr. President, today I am introducing legislation which would grant a narrow waiver to the Jones Act for two vessels to operate in coastwise trade.

The vessels, both named *Gallant Lady*, would be authorized under the bill to be used to assist charitable organizations in their fundraising activities.

The waiver would expire if the owner sold the vessels. Further, the owner must agree prior to October 1, 1996, to have a vessel of at least 130 feet built by a U.S. shipyard.

I am hopeful the Senate will approve this legislation and look forward to working with my colleagues to ensure that the bill meets its narrow goals.

By Mr. PRESSLER:

S. 2390. A bill entitled the "Mentorship for American Indian Small Enterprise Act"; to the Committee on Indian Affairs.

MENTORSHIP FOR AMERICAN INDIAN SMALL BUSINESS ENTERPRISE ACT

Mr. PRESSLER. Mr. President, I rise today to introduce a bill creating the Mentorship for American Indian Small Enterprise [MAISE] Program. This legislation targets a portion of section 7(m) of the Small Business Act, the Small Business Administration's Microloan Demonstration Program, for Indian lands experiencing severe economic stagnation.

The concept of this legislation was born out of a hearing I chaired in Pine Ridge, SD, in September of 1993. The hearing, the first ever of the Senate Small Business Committee on an Indian reservation, was held on the Pine Ridge Indian reservation. Pine Ridge contains the Nation's poorest county on a per capita basis, vividly demonstrating the dire economic conditions that often have persisted on Indian reservations. The three panels of witnesses included tribal, State, and community leaders, as well as entrepreneurs and private lenders. While the testimony acknowledged and addressed the unfortunate circumstances existing on most Indian lands, witnesses focused on solutions to the problems that stunt job creation and entrepreneurial success.

Small business development will not and cannot be a panacea to the profound and complex problems that American Indians experience. Business opportunity, however, is a proven pathway to economic independence. My bill provides some of the tools necessary for American Indians caught in a seemingly endless cycle of economic dependency to break out of that defeating spiral. Although my greater MAISE concept will include welfare reform and tax incentives, committee jurisdictional complications prevent me from offering all of the program as a single piece of legislation. Nonetheless, the Microloan portion of the MAISE Program eventually could allow aspiring entrepreneurs to learn from established members of the local business community and put themselves firmly on the road to success.

As I mentioned earlier, there tools would be provided by modifying the SMA microloan Program, found under section 7(m) of the Small Business Act. This bill takes a comprehensive approach to stimulating economic growth on Indian lands by adding another tier of assistance to the existing Microloan Program. My bill would target a portion of the current program by requiring the SBA to select no less than the ten percent of participating intermediaries to provide loans and technical assistance to members of qualified Indian tribes. A qualified Indian tribe, as defined in the act, must have "an employable adult population of not less than 400 persons" and "an unemployment rate of not less than 40 percent." This reserve parallels a portion of the current program requiring at least 50 percent of intermediaries to serve rural areas. This reserve is not designed to act as a quota or mandate; rather, it is a primer for these particularly needy areas to become full partners in the SBA Microloan Program.

In addition to intermediary involvement, the legislation provides technical assistance grants to be awarded to institutions of higher education. Tribal, State, or private colleges or universities would provide training to intermediaries and established members of the business community—referred to as mentors in this legislation. With the cooperation of the intermediaries, these mentors would bolster their personal business knowledge with formal instruction so that they, in turn, could advise fledgling entrepreneurs.

The bill also amens the purposes for which microloans may be used. Under current statute, microloans may be used for "working capital or the acquisition of materials, supplies, or equipment." This bill would allow loans to be used for the purchase of commercial real estate in addition to these other purposes. Inexpensive real estate is readily accessible not only to businesses located on Indian reservations, but also to many businesses located in rural areas and cities. South Dakota's only participating intermediary in the SBA Microloan Program, the Northeast South Dakota Energy Conservation Corp. [NESDECC], recently informed me that almost half of the businesses seeking microloans from NESDECC would like to use such loans to purchase commercial real estate. NESDECC also stated that many buildings in the area it serves can be purchased for as little as $5,000. To allay fears that introducing real estate loans to the Microloan Program may jeopardize its revolving fund concept, my colleagues should know that this legislation does nothing to modify the $25,000 loan limit, or the $10,000 average loan portfolio requirement of the current law. I believe these two provisions provide an adequate safeguard against intermediaries making too many large, long-term loans.

Mr. President, I truly believe this program would be an excellent way for this Nation's Indian reservations to work their way out of economic stagnation. The Microloan Program was created specifically "to assist women, low-income, and minority entrepreneurs and business owners." By coupling intensive business assistance with access to credit, this program could be just the catalyst that budding American Indian entrepreneurs need to hone their skills and talents. Such a tremendous resource and such enormous potential must not continue to go to waste. The MAISE Program will transform ideas into reality and allow economically disadvantaged American Indians to declare social and economic independence.

The legislation I introduce today owes a great deal to the honest, straight forward testimony of people like Elsie Meeks, executive director of the Lakota Fund of Kyle, SD. At the Pine Ridge field hearing, Elsie explained the value of microenterprise development to Indian reservations. She stated that microenterprise development reaches out to the "poorest of the poor" and puts them on "the road to economic self-sufficiency." Despite the limited business skills and depressed economic conditions that surround these new businesses, the Lakota Fund maintains a default rate below 10 percent. Another microlender, the Sincangu Enterprise Center located on the Rosebud Indian Reservation, serves as another powerful example of how microlending can empower the once impoverished. Sincangu has been fortunate enough to have the support of Farmers State Bank of Mission, SD. Farmers State Bank, located just off of the Rosebud Reservation, has built a strong working relationship with the members of the Rosebud Sioux tribe, as well as with the Sincangu Enterprise Center. Cooperative efforts among this bank, Sinte Gleska University, and the people of the Rosebud area have allowed the Sincangu Enterprise Center to create over 30 new small businesses in the last 4 years.

Since last September, I have kept in close contact with many of the witnesses who testified at this hearing. They have been instrumental to the development of this bill. Their advice and assistance carries the utmost importance and credibility on this subject.

They are, after all, the individuals who live and work in these communities and deal with the problems there every day. Clearly, they know what it will take to make their communities prosper. I believe that this bill captures that spirit.

Mr. President, I ask unanimous consent that the bill and a section-by-section analysis of the legislation be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

S. 2390

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. MICROLOAN DEMONSTRATION PROGRAM AMENDMENTS.

(a) PURPOSES.—Section 7(m)(1)(A)(iii) of the Small Business Act (15 U.S.C. 636(m)(1)(A)(iii)) is amended—

(1) in subclause (I), by inserting "commercial real estate," after "acquisition of"; and

(2) in subclause (III), by striking "and" at the end;

(3) by redesignating subclause (IV) as subclause (VI); and

(4) by inserting after subclause (III) the following new subclauses:

"(IV) to make grants to eligible intermediaries that, together with non-Federal matching funds, will enable such intermediaries to provide marketing, management, and technical assistance to microloan borrowers that are members of qualified Indian tribes;

"(V) to make grants to institutions of higher education serving Indian lands that, together with non-Federal matching funds, will enable such institutions to provide instruction on marketing, management, and technical assistance to eligible intermediaries and to mentors, in order to enable such intermediaries and mentors to assist members of qualified Indian tribes to obtain private sector financing for their businesses, with or without loan guarantees; and".

(b) ESTABLISHMENT.—Section 7(m)(1)(B) of the Small Business Act (15 U.S.C. 636(m)(1)(B)) is amended—

(1) in clause (ii), by striking "and" at the end;

(2) in clause (iii), by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following new clauses:

"(iv) in conjunction with loans made under clause (i) and subject to the requirements of paragraph (4), make grants to eligible intermediaries for the purpose of providing marketing, management, and technical assistance to members of qualified Indian tribes that are seeking to start or enlarge their small business concerns and that are borrowers under this subsection; and

"(v) subject to the requirements of paragraph (7), make grants to institutions of higher education serving Indian lands for the purpose of providing instruction on marketing, management, and technical assistance to eligible intermediaries and to mentors, in order to enable such intermediaries and mentors to assist members of qualified Indian tribes to obtain private sector financing for their businesses, with or without loan guarantees.".

(c) INTERMEDIARY APPLICATIONS.—Section 7(m)(3)(A)(i) of the Small Business Act (15 U.S.C. 636(m)(3)(A)(i)) is amended—

(1) in subclause (VII), by striking "and" at the end;

(2) in subclause (VIII), by striking the period at the end and inserting "; and"; and

(3) by adding at the end the following new subclause:

"(IX) with respect to eligible intermediaries serving Indian lands, any plan to work with—

"(aa) an institution of higher education that has received a grant under paragraph (1)(B)(v); or

"(bb) a mentor that has received training from any such institution of higher education pursuant to such a grant.".

(d) ADDITIONAL TECHNICAL ASSISTANCE GRANTS FOR MAKING CERTAIN LOANS.—Section 7(m)(4) of the Small Business Act (15 U.S.C. 636(m)(4)) is amended in the matter preceding subparagraph (A), by striking "subparagraph (B)(ii) of paragraph (1)" and inserting "clause (ii) or (iv) of paragraph (1)(B)".

(e) LOANS FROM ELIGIBLE INTERMEDIARIES.—Section 7(m)(6)(A) of the Small Business Act (15 U.S.C. 636(m)(6)(A)) is amended by inserting "commercial real estate," after "acquisition of".

(f) GRANTS TO INSTITUTIONS OF HIGHER EDUCATION.—Section 7(m) of the Small Business Act (15 U.S.C. 636(m)) is amended—

(1) by redesignating paragraphs (7) through (11) as paragraphs (9) through (13), respectively; and

(2) by inserting after paragraph (6) the following new subparagraph:

"(7) GRANTS TO INSTITUTIONS OF HIGHER EDUCATION.—Grants made in accordance with paragraph (1)(B)(v) shall be subject to the following requirements:

"(A) GRANT AMOUNTS.—For each eligible intermediary receiving a grant under paragraph (1)(B)(iv), 1 grant shall be made to a qualified institution of higher education serving the same tribal lands as the eligible intermediary. The amount of the grant to the institution of higher education shall not exceed the grant amount received by the eligible intermediary pursuant to paragraph (1)(B)(iv).

"(B) CONTRIBUTION.—As a condition of any grant made under subparagraph (A), the Administration shall require the institution of higher education to contribute an amount equal to 25 percent of the amount of the grant, obtained solely from non-Federal sources. In addition to cash or other direct funding, the contribution may include indirect costs or in-kind contributions paid for under non-Federal programs.

"(C) INDIAN MENTOR EDUCATION GRANTS.—Institutions of higher education receiving grants under paragraph (1)(B)(v) shall be eligible to receive grants to educate owners, managers, or employees of established small business concerns for purposes of providing additional technical assistance to small business concerns located on or near Indian lands that are borrowers under this subsection, as well as to other small business concerns seeking private sector financing.".

(g) INDIAN ASSISTANCE.—Section 7(m) of the Small Business Act (15 U.S.C. 636(m)) is amended by inserting after paragraph (7), as added by subsection (f), the following new paragraph:

"(8) INDIAN ASSISTANCE.—In funding microloan programs, the Administration shall ensure that not less than 10 percent of the programs funded under this subsection will provide microloans to small business concerns located on or near Indian lands.".

(h) REPORT TO CONGRESS.—Section 7(m)(12)(F) of the Small Business Act (15 U.S.C. 636(m)(12)(F)), as redesignated by subsection (f), is amended by inserting "and to small business concerns located on or near Indian lands" immediately before the semicolon.

(i) DEFINITIONS.—Section 7(m)(13) of the Small Business Act (15 U.S.C. 636(m)(13)), as redesignated by subsection (f), is amended—

(1) in subparagraph (C), by striking the period at the end and inserting a semicolon; and

(2) by adding at the end the following new subparagraphs:

"(D) the term 'Indian lands' has the same meaning as in section 4(4) of the Indian Gaming Regulatory Act;

"(E) the term 'Indian tribe' has the same meaning as in section 4(e) of the Indian Self-Determination and Education Assistance Act;

"(F) the term 'institution of higher education' has the same meaning as in section 1201(a) of the Higher Education Act of 1965;

"(G) the term 'mentor' means a business concern that demonstrates, to the satisfaction of the Administration, the capability to assist members of qualified Indian tribes to obtain private sector financing for their businesses, with or without loan guarantees; and

"(H) the term 'qualified Indian tribe' means an Indian tribe with—

"(i) an employable adult population of not less than 400 persons; and

"(ii) an unemployment rate of not less than 40 percent;

based on the statistics of the Bureau of Indian Affairs, Department of the Interior.".

SEC. 2. IMPLEMENTATION.

Not later than 270 days after the date of enactment of this Act, the Small Business Administration shall promulgate final regulations implementing the amendments made by section 1.

SEC. 3. REPORT TO CONGRESS.

Not later than 180 days after the effective date of the regulations promulgated in accordance with section 2, the Small Business Administration shall report to the Congress regarding the effectiveness of the amendments made by section 1 in improving the small business climate and promoting business development on or near Indian lands, as such term is defined in section 7(m)(13) of the Small Business Act.

SECTION-BY-SECTION ANALYSIS OF THE MENTORSHIP FOR AMERICAN INDIAN SMALL ENTERPRISE ACT

The Mentorship for American Indian Small Enterprise (MAISE) Act would stimulate job creation on or near Indian reservations through small business creation. This legislation would target a portion of the current Small Business Administration Microloan Demonstration Program (Section 7(m) of the Small Business Act) for small businesses located on or near Indian reservations. This legislation also would amend the existing statute to allow all microloans to be use for purchase of commercial real estate.

Section 1. Microloan Demonstration Program amendments:

(a) Purposes:

(1–2) Allows all microloans to be used for purchase of commercial real estate.

(3–4) Makes grants available to intermediaries for the purpose of providing technical assistance to prospective or established American Indian small business owners.

Creates grants for institutions of higher education serving Indian lands. These grants

would be used by colleges and universities to educate intermediaries and mentors. Mentors would supplement intermediaries' efforts to assist new businesses and start-ups to offer technical assistance.

(b) Establishment:

(1–3) Establishes that technical assistance grants would be made available to intermediaries helping American Indian small business concerns to secure loans.

Establishes grants to higher education institutions for technical assistance to intermediaries and mentors to help American Indian small businesses secure loans.

(c) Intermediary Applications:

(1–3) Adds new intermediary application requirements for those serving Indian lands by asking for information regarding plans to work with colleges and universities that have received grants under this program, as well as plans to work with mentors.

(d) Additional Technical Assistance Grants:

Amends this reference to include new provisions for American Indian intermediaries.

(e) Loans From Eligible Intermediaries:

Allows all microloans to be used for the acquisition of commercial real estate.

(f) Grants to Institutions of Higher Education:

Establishes a new subparagraph (7) outlining provisions of the higher education grants.

Allows for one grant recipient serving an Indian land, which also has an eligible intermediary serving the same Indian land.

Requires the institution to supplement grants with non-Federal contributions of at least 25 percent of the Federal contribution.

Describes the purpose of the grant as a means of educating mentors.

(g) Indian Assistance:

Ensures that not less than ten percent of all intermediaries participating in the SBA Microloan Program provide microloans to small businesses located on or near Indian lands.

(h) Report to Congress:

Specifies that the SBA would report to Congress on the program's effect upon American Indian small business development.

(i) Definitions:

Provides definitions of Indian lands, institution of higher education, mentor, and

Qualified Indian Tribe—Indian tribe with a workforce of at least 400 persons and an unemployment rate of at least 40 percent.

Section 2. Implementation:

Regulations shall be promulgated by the SBA not later than 270 days after enactment.

Section 3. Report to Congress:

SBA would report to Congress not later than 180 days after regulations are promulgated.

By Mr. JOHNSTON (by request):

S.J. Res. 217. A joint resolution to approve the location of a World War II Memorial; to the Committee on Energy and Natural Resources.

APPROVAL OF THE LOCATION FOR THE WWII MEMORIAL

Mr. JOHNSTON. Mr. President, at the request of the Department of the Interior, I send to the desk a joint resolution approving the location of a World War II memorial.

Mr. President, this draft legislation was submitted and recommended by the Department of the Interior, and I ask unanimous consent that the joint resolution, and the communication which accompanied the proposal from the Secretary be printed in the CONGRESSIONAL RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

S.J. RES. 217

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled,

Whereas section 6(a) of the Act entitled "To provide standards for placement of commemorative works on certain Federal lands in the District of Columbia and its environs, and for other purposes," approved November 14, 1986 (Public Law 99–652, 100 Stat. 3650), provides that the location of a commemorative work in the area described therein as Area I shall be deemed disapproved unless the location is approved by law not later than 150 days after the Secretary of the Interior or the Administrator of General Services notifies the Congress of his determination that the commemorative work may be located in Area I; and

Whereas Public Law 103–32, approved May 25, 1993 (107 Stat. 90), authorized the American Battle Monuments Commission to establish a memorial on Federal land in the District of Columbia to members of the Armed Forces who served in World War II; and

Whereas the Secretary of the Interior has notified the Congress of his determination that the memorial may be located in Area I: Now, therefore, be it

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That the location of a World War II Memorial, authorized by Public Law 103–32, within either Area I or Area II as described in Public Law 99–652 (100 Stat. 3650), is hereby approved.

THE SECRETARY OF THE INTERIOR,
Washington, DC, August 8, 1994.

Hon. ALBERT GORE, JR.,
President of the Senate, Washington, DC.

DEAR MR. PRESIDENT: There is enclosed a draft joint resolution, "To approve the location of a World War II Memorial." We recommend that the joint resolution be introduced, referred to the appropriate committee for consideration, and enacted.

Public Law 103–32 (May 25, 1993, 107 Stat. 90) authorized the American Battle Monuments Commission to establish a memorial on Federal land in the District of Columbia to members of the Armed Forces who fought in World War II and to commemorate United States participation in that conflict.

The enclosed draft joint resolution would grant authority to consider location of the World War II Memorial in Area I, the area comprising the central monumental core of the District of Columbia as defined by Public Law 99–652 (November 14, 1986, 100 Stat. 3650; hereinafter referred to as "the Act".)

The American Battle Monuments Commission has made this request so that all sites within Area I and Area II as defined by the Act may be available for consideration as the site for the World War II Memorial. Section 6(a) of the Act provides that the Secretary of the Interior (the Secretary) may approve the location of a commemorative work in Area I only if he finds that the subject of the work is of preeminent historical and lasting significance to the Nation. That section further provides that the Secretary, after consultation with the National Capital Memorial Commission, shall notify the Congress of his determination that a commemorative work may be located in Area I. Further, the Act provides that an Area I location shall be deemed disapproved unless within 150 days of the notification it is approved by law by the Congress.

On September 2, 1993, the National Capital Memorial Commission recommended that the World War II Memorial is eligible for location within Area I. I agree with this determination, and find the subject to be of preeminent historical and lasting significance to the Nation. I recommend that the World War II Memorial may be located within Area I.

In accordance with section 6(a) of the Act approved November 14, 1986, notice is hereby given that I recommend the potential location of this authorized memorial in Area I, that through my designee, I have consulted with the National Capital Memorial Commission, and that I have determined that the World War II Memorial may be located in Area I. Under section 6(a) of the Act, the recommendation for Area I location shall be deemed disapproved unless, within 150 days after this notification, this recommendation is approved by law. Therefore, we urge prompt action on the enclosed joint resolution.

The Office of Management and Budget has advised that there is no objection to the submission of this letter from the standpoint of the Administration's program.

Sincerely,

BRUCE BABBITT,
Secretary.

ADDITIONAL COSPONSORS

S. 277

At the request of Mr. SIMON, the name of the Senator from Vermont [Mr. JEFFORDS] was added as a cosponsor of S. 277, a bill to authorize the establishment of the National African American Museum within the Smithsonian Institution.

S. 1726

At the request of Mr. SIMON, the names of the Senator from Missouri [Mr. DANFORTH], the Senator from Missouri [Mr. BOND], and the Senator from Illinois [Ms. MOSELEY-BRAUN] were added as cosponsors of S. 1726, a bill to provide for a competition to select the architectural plans for a museum to be built on the East Saint Louis portion of the Jefferson National Expansion Memorial, and for other purposes.

S. 1822

At the request of Mr. HOLLINGS, the name of the Senator from Connecticut [Mr. LIEBERMAN] was added as a cosponsor of S. 1822, a bill to foster the further development of the Nation's telecommunications infrastructure and protection of the public interest, and for other purposes.

S. 2081

At the request of Mr. GREGG, the name of the Senator from Mississippi [Mr. LOTT] was added as a cosponsor of S. 2081, a bill to amend the Internal Revenue Code of 1986 to treat recycling facilities as exempt facilities under the tax-exempt bond rules, and for other purposes.

S. 2242

At the request of Mr. DASCHLE, the name of the Senator from Illinois [Mr.

SIMON] was added as a cosponsor of S. 2242, a bill to establish a National Institute for the Environment, to improve the scientific basis for decisionmaking on environmental issues, and for other purposes.

S. 2288

At the request of Mr. GREGG, the name of the Senator from Mississippi [Mr. COCHRAN] was added as a cosponsor of S. 2288, a bill to amend the Internal Revenue Code of 1986 to provide that a foster care provider and a qualified foster individual may share the same home.

S. 2330

At the request of Mr. ROCKEFELLER, the names of the Senator from Alaska [Mr. STEVENS] and the Senator from Mississippi [Mr. LOTT] were added as cosponsors of S. 2330, a bill to amend title 38, United States Code, to provide that undiagnosed illnesses constitute diseases for purposes of entitlement of veterans to disability compensation for service-connected diseases, and for other purposes.

S. 2347

At the request of Mr. SASSER, the name of the Senator from New Jersey [Mr. LAUTENBERG] was added as a cosponsor of S. 2347, a bill to require the Secretary of the Treasury to mint coins in commemoration of the 150th anniversary of the founding of the Smithsonian Institution.

SENATE CONCURRENT RESOLUTION 66

At the request of Ms. MIKULSKI, the name of the Senator from Alaska [Mr. STEVENS] was added as a cosponsor of Senate Concurrent Resolution 66, a concurrent resolution to recognize and encourage the convening of a National Silver Haired Congress.

SENATE CONCURRENT RESOLUTION 69

At the request of Mr. METZENBAUM, the name of the Senator from Michigan [Mr. RIEGLE] was added as a cosponsor of Senate Concurrent Resolution 69, a concurrent resolution expressing the sense of the Congress that any legislation that is enacted to provide for national health care reform should provide for compensation for poison control center services, and that a commission should be established to study the delivery and funding for poison control services.

SENATE RESOLUTION 249—AUTHORIZING TESTIMONY BY AN EMPLOYEE OF THE SENATE AND REPRESENTATION BY SENATE LEGAL COUNSEL

Mr. FORD (for himself and Mr. DOLE) submitted the following resolution, which was considered and agreed to:

S. RES. 249

Whereas, the Department of Justice has caused a subpoena to be issued for the testimony of Mary Leblanc, an employee of the Senate on the staff of Senator George J. Mitchell, as a witness in connection with a pending investigation into potential fraud by private citizens in Farmers Home Administration programs;

Whereas, by the privileges of the Senate of the United States and Rule XI of the Standing Rules of the Senate, no evidence under the control or in the possession of the Senate can, by administrative or judicial process, be taken from such control or possession but by permission of the Senate;

Whereas, when it appears that evidence under the control or in the possession of the Senate is needed for the promotion of justice, the Senate will take such action as will promote the ends of justice consistent with the privileges of the Senate;

Whereas, pursuant to sections 703(a) and 704(a)(2) of the Ethics in Government Act of 1978, 2 U.S.C. §§288b(a) and 288c(a)(2), the Senate may direct its counsel to represent employees of the Senate with respect to subpoenas issued to them in their official capacities: Now, therefore, be it

Resolved, That Mary Leblanc is authorized to testify in conjunction with the law enforcement investigations or related proceedings, except concerning matters for which a privilege should be asserted.

SEC. 2. The Senate Legal Counsel is authorized to represent Mary Leblanc in connection with the testimony authorized by section 1 of this resolution.

ADDITIONAL STATEMENTS

IN HONOR OF MS. GUADALUPE REYES AND EL VALOR: THE STRENGTH OF FEW THAT BENEFITS SO MANY

• Mr. SIMON. Mr. President, recently, I had the wonderful opportunity of meeting Ms. Guadalupe Reyes and visiting her organization, the El Valor Corp. Ms. Reyes founded El Valor, the first bilingual rehabilitation program for Hispanics in Illinois, to foster education and achievement for individuals with disabilities and their families.

El Valor works with government, business, individuals, and the community to prevent inner-city children and adults from falling behind and not reaching their fullest academic and intellectual potential. El Valor, under Ms. Reyes's leadership, continues to affect approximately 1,000 adults and children a year through positive and stimulating interaction.

Approximately 20 years ago, Ms. Guadalupe Reyes could not find a rehabilitation center for her son, Bobby, who had spinal meningitis. Since Ms. Reyes did not want to place her son in an institution and she could not find a center to help him, she took it upon herself to create one. Ms. Reyes believed that there were other families like hers, faced with a similar dilemma. She started an arts and crafts program in the basement of a church. When Ms. Reyes realized that the basement could not accommodate everyone who wanted to participate, she began to take out loans and El Valor gradually expanded to become the organization that it is today.

Since Ms. Reyes's first vocational programs in the basement of a church, El Valor has moved forward to address other concerns within the community. El Valor's latest undertaking is a program called Tocar el Futuro, or Touch the Future. Tocar el Futuro empowers the inner-city community to provide early intervention and educational awareness to benefit those who need it the most.

To grasp the strength of Ms. Reyes, one must look beyond El Valor. Ms. Reyes works with several other organizations to benefit her community and the rest of society. She works with the Harrison Parks Seniors. She recently was appointed to the Chicago Transit Authority Board. Her talents have passed onto her children; her daughter Mary Gonzales founded Pilsen Neighbors to motivate and unify her community.

Ms. Reyes has worked with companies and residents to expand vocational and rehabilitative services. Ms. Reyes is an advocate for her community and is driven to make a difference. She looks at her society and sees not what is wrong but what can be done.

I congratulate Ms. Guadalupe Reyes for her strength and care to create an extraordinary organization through her efforts. I congratulate those who work with Ms. Reyes and enhance the community through their own efforts. Imagine what could change in our society if every individual had the same spirit and energy as Ms. Guadalupe Reyes.•

COMMUNITY DEVELOPMENT BANKING ACT—H.R. 3474

• Mr. BOND. Mr. President, I strongly support H.R. 3474, the Community Development Banking Act. This conference bill reflects a true bipartisan compromise on legislation that addresses a number of key issues important to the American public and American businesses. The bill includes significant provisions intended to enhance the development of community development banking and small business capital formation, provisions designed to reduce bank paperwork requirements and provide bank regulatory relief, provisions to reform money laundering statutes, and provisions to reform the National Flood Insurance Program.

All titles of the bill merit support in my view. The community development bank provisions in title I of the legislation focus on helping to revitalize our distressed communities through the infusion of capital. These provisions also recognize the important contributions that traditional financial institutions can provide to distressed communities by allowing banks and other entities to form community partnerships with community development financial institutions.

Title II of the legislation is designed to increase the ability of small businesses to access capital by removing

existing impediments to the securitization of small business loans. Small business is the backbone of our Nation's economy and part of the American dream. It is high time that we take steps to ensure the availability of credit to these businesses. I hope that these provisions will help create new jobs and stimulate economic growth.

Title III of the bill provides a number of important provisions intended to reduce paperwork and regulatory burden on financial institutions through measures which require the bank regulatory agencies to streamline rules and regulations, coordinate examinations, modernize reporting, and establish a regulatory appeals process. These provisions are a critical first step and I trust that we will be able to continue to address unnecessary regulatory burden on banks in future bills and in the next Congress.

Title IV of the legislation makes a number of reforms and changes to existing laws regarding money laundering. These provisions should reduce the regulatory burden on financial institutions while providing better safeguards against money laundering schemes.

Title V of the bill provides a number of comprehensive reforms to the National Flood Insurance Program. I have been deeply involved in the development of this legislation and consider its enactment critical. In particular, two of the largest rivers in the world run through Missouri, and the State also claims a number of major tributaries. Because of the tragic flooding of 1993, it should be clear to everyone that for Missouri to continue to prosper, our citizens must be able to insure against the possibility and, in a few cases, even the probability, of flooding. Currently, almost 15,000 Missouri policies provide more than $760 million in flood insurance coverage for homes and businesses.

The key elements of the flood insurance reform legislation include strict requirements to ensure the placement of flood insurance on properties in flood-prone areas; an increase in flood insurance coverage; the establishment of a community rating system to provide premium rate credits for communities that implement land use and loss control measures that exceed minimum criteria; and the establishment of new programs for mitigation assistance.

I, however, do want to make it clear that the National Flood Insurance Program is not intended to provide the Federal Government with a backdoor for implementing environmental policies by overriding local land use control and decisionmaking. In particular, the bill conferees specifically removed a House provision that would have established an environmental purpose for the National Flood Insurance Program. Again, I emphasize that the Federal Government should defer, whenever possible, to State and local land use decisionmaking.●

IN HONOR OF PROF. LOUIS STERN: THE 1994 AMA/ERWIN DISTINGUISHED MARKETING EDUCATOR

● Mr. SIMON. Mr. President, it is with great honor that I congratulate Prof. Louis W. Stern for receiving the AMA/Erwin Distinguished Marketing Educator Award for 1994. He received the AMA/Erwin Award on Sunday, August 7, at a ceremony held by the American Marketing Association. Mr. Stern is the 10th individual to have received this award.

As Representative PETER W. BARCA states, "Louis Stern is known as the father of modern channels research, having introduced the concepts of power and conflict to marketing channels."

Professor Stern shares his knowledge and creativity through his various publications that involve marketing management, behavioral science, and law. He continues to dedicate his talents to higher education at Northwestern University's Kellogg Graduate School of Management.

Again, I congratulate Prof. Louis Stern for his award and wish him well in his future endeavors.●

AUTHORITY TO TESTIFY WITH REPRESENTATION

Mr. DASCHLE. On behalf of the majority whip and the Republican leader, I send a resolution to the desk authorizing a Senate employee to testify with representation, and I ask unanimous consent that the Senate proceed to its immediate consideration; that the resolution be agreed to; that the preamble be agreed to; that the motion to reconsider be laid upon the table; and that a statement by Senator FORD appear at the appropriate place in the RECORD.

Mr. DURENBERGER. We have no objection.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. FORD. Mr. President, the Department of Justice has caused a subpoena to be issued to a Senate employee on Senator MITCHELL's staff named Mary Leblanc to testify in connection with a pending investigation into potential fraud in Farmers Home Administration programs. The Justice Department's investigation is into possible wrongdoing by private citizens in connection with applications for Federal loan assistance. The Department has advised the Office of Senate Legal Counsel with regard to this subpoena that no wrongdoing by anyone on Senator MITCHELL's staff is in any way involved.

In response to this subpoena, this resolution would authorize Mary Leblanc to testify in this investigation and to be represented by the Senate Legal Counsel.

So the resolution was agreed to.

The preamble was agreed to.

The resolution (S. Res. 249), with its preamble, is as follows:

S. RES. 249

Whereas, the Department of Justice has caused a subpoena to be issued for the testimony of Mary Leblanc, an employee of the Senate on the staff of Senator George J. Mitchell, as a witness in connection with a pending investigation into potential fraud by private citizens in Farmers Home Administration programs;

Whereas, by the privileges of the Senate of the United States and Rule XI of the Standing Rules of the Senate, no evidence under the control or in the possession of the Senate can, by administrative or judicial process, be taken from such control or possession but by permission of the Senate;

Whereas, when it appears that evidence under the control or in the possession of the Senate is needed for the promotion of justice, the Senate will take such action as will promote the ends of justice consistent with the privileges of the Senate;

Whereas, pursuant to sections 703(a) and 704(a)(2) of the Ethics in Government Act of 1978, 2 U.S.C. §§288b(a) and 288c(a)(2), the Senate may direct its counsel to represent employees of the Senate with respect to subpoenas issued to them in their official capacities: Now, therefore, be it

Resolved, That Mary Leblanc is authorized to testify in conjunction with law enforcement investigations or related proceedings, except concerning matters for which a privilege should be asserted.

SEC. 2. The Senate Legal Counsel is authorized to represent Mary Leblanc in connection with the testimony authorized by section 1 of this resolution.

ORDERS FOR TUESDAY, AUGUST 16, 1994

Mr. DASCHLE. Mr. President, on behalf of the majority leader, I ask unanimous consent that when the Senate completes its business today, it stand in recess until 9:15 a.m. Tuesday, August 16; that following the prayer, the Journal of the proceedings be deemed approved to date, and the time for the two leaders reserved for their use later in the day; that there be a period for morning business with Senators permitted to speak therein for up to 5 minutes each, with Senator METZENBAUM recognized to speak up to 15 minutes; and that at 9:30 the Senate resume consideration of S. 2351, the Health Security Act; that on Tuesday, the Senate stand in recess from 12:30 p.m. to 2:15 p.m. in order to accommodate the respective party conferences.

The PRESIDING OFFICER. Without objection, it is so ordered.

ORDER FOR RECESS UNTIL 9:15 A.M. TOMORROW

Mr. DASCHLE. Mr. President, I ask unanimous consent that upon the conclusion of the remarks by the Senator from Minnesota, the Senate stand in recess as previously ordered.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. DASCHLE. I thank again my colleague from Minnesota and I thank the Chair.

The PRESIDING OFFICER. The Chair recognizes the Senator from Minnesota.

HEALTH CARE REFORM

Mr. DURENBERGER. Mr. President, I really appreciate the indulgence of the Senator from Hawaii, who is currently occupying the chair. The hour is late and the majority leader has already announced that we may be here all night and morning tomorrow. So I wish to express, as I begin my comments, my appreciation to him and maybe more particularly, since he is elected to do that, to all of the staff here at the same time who are not able to leave until I finish this statement.

The comment by my colleague from South Dakota about health care reform, about an understanding of Government's role, reminds me that we are going to be here for quite a while. If we cannot understand the difference between the Federal Employee Health Benefit Plan and Government-run programs like Medicare and Medicaid, I, for one, am going to spend a lot of time here educating my colleagues, and I do not want anybody to call it a filibuster.

The Federal Employee Health Benefit Plan, or plans, if you will, are a series of health plans which all of us have an opportunity to buy. But they are all private plans everybody in this community can buy if they have an employer who provides it to them or they can buy it in the open market.

There are Blue Cross/Blue Shield plans in that, and I think there is a Kaiser plan in this community, but they are private plans. What they do is ensure all of our access to the doctors, hospitals, and so forth, that we need in this area—Washington, DC, northern Virginia, Maryland, and so forth—but it is basically a private plan.

It is an American system. The doctors and hospitals set the fees. They charge the insurance companies. The insurance companies pay the bills. You pay your deductible or your cost share, something like that. That is an American system. This one happens to be very costly.

I can get the same health plan in Minnesota for half of what I pay for it here, for example, and you are all paying 72 percent of that bill. But it shows you that health care costs in one community can differ substantially from another.

My son and his wife just had a child by cesarean section in St. Paul, MI. It was about $6,000 for the doctor and hospital bill. Here in this community it is like $14,000, $15,000. That is why your health care expenses are so high in this community. But it is still basically your American system.

But inside that American system we run a Canadian system. We run it right here. For the poor, it is called Medicaid because they are welfare eligible. For the elderly, it is called Medicare. For people with disabilities, it is Medicare. But it is run by the Government. All the prices are set right here by the Government, just like in Canada. There are 7,000 procedures that doctors can use and each one has a dollar value, and we set that value, or it is set over here, just like Canada. There are 468 procedures in hospitals. Every one of them has a price put on it by a Government agency and that is what is paid. Every year we decide how much money we are going to spend on Medicaid—we, the Government—and Medicare. And to the extent that the cost to the doctors and hospitals goes up faster than what we pay, what do you suppose happens to the difference? The difference is shifted onto the private system here in the District of Columbia or back home.

So make no mistake about it, we are running a Canadian system right inside America, in every community in this country. It is called Medicare and Medicaid.

It is about time we stopped it. It is about time we stopped it. If we did not have an American system around onto which we could shift the bills, we would be in trouble because you cannot keep working for 59-cent dollars if you are a doctor. You cannot keep working for 71-cent dollars if you are a hospital. It does not work. So only the cost shift makes it possible to keep doctors and hospitals serving Medicare and Medicaid patients.

But suppose everybody were in a Government system and all doctors got paid 59 cents on the dollar and all hospitals got a buck on the dollar. You would not have doctors and hospitals. That is what is happening in Calgary, and that is what is happening in Canada. If the Canadians did not have a United States, there would not be any medicine in Canada, and it would cost a lot more.

So when people make these comparisons about how cheaply it is done up there, and so forth, versus what is done down here, remember, the same thing is happening right here in your own community.

Health care reform used to be, and maybe still is, possible. But Bill Clinton says we cannot find an immediate solution to the health care reform problem because BOB DOLE "never stops moving to his right." How many times have we heard that statement? BOB DOLE keeps moving to his right so we cannot get him to stop and get health care reform.

Well, BOB DOLE about 5, 6 weeks ago decided he was not moving anymore, if that is what they were accusing him of. He introduced a bill with 40 Republicans on it, and he stopped moving. There it is.

There it is. So we are waiting for President Clinton to decide how close to BOB DOLE he is going to come. That is what this whole issue is all about. The other fear in all of this, and let us say that is Bill Clinton's problem right now, he cannot figure out if he is fearful of what BOB DOLE might do. I doubt that he might fear BOB DOLE might move any further. BOB DOLE's concern is there are four Republican Senators who might sign on to a modified version of Senator MITCHELL's bill thus depriving him the power of the filibuster. That is the other side of this problem. If the Mitchell bill is as bad as we all say it is, and I believe it is—I will not take your time tonight to debate that, you can understand why the minority leader, the Republican leader, with the responsibility riding on his shoulder—83 percent of my phone calls from Minnesota, and over 2,000 we have gotten, are all negative on this health reform bill. Look at the responsibility he has. He has four Republican Senators that might switch, leaving him with only 40 votes. What does he do? So unfortunately, a lot of this debate is driven by leadership concerns.

Tomorrow those of us in the so-called mainstream rump group on our right will present our package of bills. It is very similar to the bill that Senator CHAFEE and others put together called S. 1770, as modified by the work we did on the Finance Committee, the learning curve that we have all been on; very bipartisan arrangement. We had 17 Members at the last meeting, Democrats and Republicans. It is no longer just a handful of us. It certainly is not just three Republicans who started out on it.

Tomorrow, I understand SAM NUNN and PETE DOMENICI and DAVID BOREN and BOB BENNETT will also put in a bipartisan bill. So you will have two major bipartisan pieces of legislation, and Senator DOLE's bill with 39 other Republicans on it. Then the question is going to be for the people on this side of the aisle, when are you going to move it? They are going to suggest to us that we ought to go through an amendment process in order to bring us to the middle. I am here to tell you that is not possible.

As I said earlier, I am on both of these committees. I have been through this several times already—the drafting process, and putting bills together. I am a cosponsor with JOHN BREAUX on a bipartisan bill which has now moved to its right, passing CHAFEE on its way, if you will. You cannot amend that bill. We would be here until the first of the year, if we were going to try to amend that Mitchell bill, not just because it is in its third iteration, because it was too complicated to begin with.

Our staffs for a dozen committees spent literally 4 straight days last Friday, Saturday, Sunday, and Monday—not this past week, but the weekend before that—going through the first iteration of the Mitchell bill. They came to us frustrated at the end of the day on Monday saying that you cannot amend it. You will not believe this language.

So it is not hardhearted filibustering over here. It is people for the most part with a genuine concern for doing health policy right who have looked at that bill, and said as a practical matter we cannot stand here, even if we got off of our opening speeches, finally, and got to the heart of this debate—we cannot stand here and make this bill what the American people deserve.

There is clearly a concern also articulated by an article today which I will ask unanimous consent be printed in the RECORD in full at the conclusion of my remarks, by Bill Safire in the New York Times called, "Why the Rush?" in which he talks among other things about, "The health care push, on the contrary, is now seen by voters for what it is: a return to Great Societyism." That is a characterization of Clinton-Mitchell.

After calling the Dole-Packwood insurance reform bill sensible, he says:

> Mitchell's first fallback position was launched as a bill to set up a compromise with a group headed by Republican Senator John Chafee of Rhode Island.
>
> Chafee had been placed at the head of the bipartisan group that has labeled itself "mainstream," not so subtly suggesting that conservative opposition to Government-dominated medicine is extremist.
>
> Obviously, Chafee is using Mitchell's liberal bill as his lodestar.

To that, I say bull. We have invested on this side of the aisle 4 years in reform breakfasts, every Thursday morning starting in August 1990, just down the hall; for an hour every Thursday morning with lots of Republican Senators. Last fall, 20 Republican Senators signed up on a John Chafee bill.

So this notion that somehow or other a rump group with CHAFEE put in charge of it is—what does he call it?—"using MITCHELL's liberal bill as his lodestar," that somehow or other we are here sneaking a Democratic bill through a Republican caucus just does not hold up.

So for those of you who think that everyone seems around this place as William Safire obviously does, maybe as some people hope, I am here to tell you there is no truth to it.

Partisan rhetoric, Mr. President, is what this debate has been characterized as. I would characterize it more as a lack of problem definition, and a substantial difference on solution as we have gone at the health care reform debate so far.

One issue in particular needs clarification. That involves what is called the standard benefit package. I have been reading since I discovered the material from the Progressive Policy Institute. Let me tell you what the Progressive Policy Institute is, although the current Chair may know what I am talking about. It is a project of the Democratic Leadership Council. It is a center for policy innovations, to develop alternatives, a conventional left-right debate. Thank God somebody is doing it.

Anyway, from the publication they put out in June of this year, let me read:

> The key issue in health care reform is this: Where should responsibility for restraining costs be lodged, in the Government or in market? PPI supports a decentralized approach, seeks to harness the power of choice, competition and market incentives to control cost, to enhance quality, to reward efficiency, to encourage innovation, and to empower consumers. It promotes individual responsibilities instead of bureaucratic micromanagement as the remedy for our current cost-unconscious health care plan.

It is a terrific presentation. They point out some of the problems in the current system. The main problem they say is what is called risk skimming in the insurance business. This is a process by which health insurance companies compete with each other by avoiding risks rather than managing them—risk skimming, in which health insurance companies compete by avoiding risks rather than managing them.

What is the answer to that? It says here on page 8: "Create a standard benefits package."

If you do not like risk skimming or risk avoidance, because it leads to cost unconscious health care financing, then the answer is to create a standard benefits package. This gives consumers a basis for comparing competing plans, like we do in the Federal employee health benefit plan, one of the few places in America where you can actually open up the book, and you can actually compare the plan. But you have to have a standard benefit package in order to compare these plans. It is not some Government scheme. It is simply a way to make a comparison, like opening up the catalog, whichever catalog you get in the mail, and see the statistics for your golf hobby, compare golf clubs, compare golf bags, and compare golf balls. That is basically what we are talking about here; competing, comparing, plans. It prevents insurers from segmenting the market by offering customized packages of benefits.

Alain Enthoven illustrates the problem of segmenting in this way: Imagine two health plans, one that offers vision care but no podiatry, and another that offers podiatry but no vision care. People with bad eyes and good feet sign up for the first plan; those with good eyes and bad feet sign up for the second. Differences in price will be irrelevant to people who choose a plan because it meets their particular needs.

Some Republicans have equated the standard package with the loss of freedom, loss of choice, loss of all of this sort of stuff we are going to lose.

Some Democrats have equated the standard benefit package with a giant entitlement program which describes every kind of a service you could possibly imagine jammed into this program. So no wonder it is confusing to people watching it.

So tonight I want to step back to the first principle and try to put a context on the discussion, and then I will suggest to my colleagues why the Dodd amendment, which is the pending business, is not good for the health of moms and babies, why a benefit package is part of insurance reform. I have already laid the ground work for this.

There seems one element of health care reform everybody wants included, and that is insurance reform. The idea of a standard benefit package is essential to insurance market reform. We all seem to agree on many of the elements—guaranteed issue, renewability, limits on preexisting conditions—but we cannot have informed consumers purchasing health plans on the basis of price, value, satisfaction with the services and quality, unless there is a similarity or a comparability about the product that is being sold.

There are 27,000—get this—in the State of North Carolina, there are 27,000 Blue Cross-Blue Shield plans. Every one of them is different. I do not mean 27,000 people with Blue Cross-Blue Shield plans; I mean 27,000 different Blue Cross-Blue Shield plans. They are going after the people with the good feet and this sort of thing. That is what is going on out there today. There are 1,400 insurance companies who are all looking for healthy people to sell insurance to.

Contracts present a confusing array of options, exclusions, and fine print. People are frustrated even if they have a choice when they discover what they bought is not what they thought it was. Let me tell you about a policy sold to the daughter of one of my staff in the State of Florida. It was offered to graduate students—she had become a graduate student at the University of Florida—by a private insurance company. She is a 24-year-old single woman. The policy excludes sports injuries, reproductive services, injuries associated with the use of drugs and alcohol, and has a lifetime limit of $200,000, and no coverage for outpatient services. The policy excludes 90 percent of what a 24-year-old woman is likely to use and, God forbid, she gets a serious illness, because in Florida, a $200,000 lifetime limit is not going to get her through a catastrophe. So the price is low, only $500 a year. She is going to discover that it is not real coverage when she experiences health problems.

We need some standardization so consumers can exercise real choice, and we need it so we can protect consumers

from risk selection through benefit design.

The Senator from Texas said earlier that 85 percent of Americans have health insurance, and most of them are happy. That is not true. It is true they have health insurance, but they are not happy. Many do not have any choice. Others know they are paying a higher price for the same product than somebody who lives next door and works for another company in the same town. We would not have started doing health insurance reform 4 years ago if all the Americans who had insurance were happy with it. They are not.

My friend, DON NICKLES, has a 22-year-old daughter who bought one of those $500 plans. He does not know yet what she bought. I hope he is listening. What DON does not know if, in fact, the law permitted him to include her on the FEHB plan, or whatever it might be, it would probably cost him and his wife $100 a year, maybe not even that.

Whether people buy an HMO or PPO, or whatever it is, everyone choosing a plan in this program knows what they are buying. What am I talking about? I am talking about the Health Insurance Plan of California, HIPC. This is like the Federal Employee Health Benefit Plan, an HMO product. They have indemnity products, and so forth. This is the HMO product. What this has is a list of the benefits on the left-hand side, and then what you must pay to get that benefit, and what some of the services are that are described in that. But the important thing is over here on the left-hand side.

This is not a list of all the services available to you; it is a list of the basic benefits to which you are entitled. And all this does is help you as a consumer compare among all the plans that are offered. Somewhere in the back of this book it lists each of the plans. You can go through each, the Sharp Health Plan, the Qual-Plan, the Smart Care Plan, and so forth. And you can get the detailed information of those plans. This is the heart of it. This is the comparison. Benefits are over here—1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, up to 14 benefits. By comparison, the Mitchell plan has 16 benefits and myriad services. The Finance Committee bill has 12 benefits. But it does not have a whole lot of services listed.

Well, the benefit plan really got its origin around here in the Federal Employee Health Benefit Plan. While we are debating whether our benefits ought to be 61 pages in length, which is a whole list of services, or just one page in length, like the Finance Committee package. Let me remind everybody that the Federal Employee Health Benefit Plan, which all of us have, is described also on one page. We do not need 61 pages of services. We do not need—and I will get to this in a minute—all of this stuff the Senator from Connecticut wants us to ram into every health plan in America. Yet, the FEHBP benefit plan is pretty simple: Hospital, surgical, in-hospital, ambulatory, supplemental, and obstetrical. Under the indemnity benefit plan are similar categories. In the Finance benefit package, there are: Inpatient and outpatient care, including hospital and health professional services, emergency services, and clinical preventive services, mental illness and substance abuse, family planning services, family planning services and services for pregnant women, prescription drugs and biological, hospice care, home health care, outpatient lab, radiology, and diagnostic, outpatient rehabilitation services, vision care, dental and hearing aids for kids under 22. That is it.

Where do the services come? They sure do not come in here, if you are smart. The services come in the plan you buy in the District of Columbia, northern Virginia, or Maryland. That is where you find all of the services. Every year you determine how well your plan is doing with the services they have agreed to provide to you. But benefits are categorized like these 12 basic benefits for the purposes of comparison, not for the purposes of making sure the chiropractors get in every plan, or that we have, as the Senator from Connecticut suggests, a periodicity schedule in all of our insurance plans in America. That is not the purpose. The services come from the plan you buy. The services are developed by your relationship with the medical professionals in your community. The benefit package is put in the statute in its 12 components, and in the case that we recommend, elaborated on by a benefit commission.

A category of covered benefits is a general term, like I have illustrated—hospital, outpatient care, whatever. It incorporates thousands of items, such as bandages, pacemakers, cancer surgery, office visits. You do not have to put that in a statute in order for you to be entitled every year to a choice of plans that will give you that service. But you need a basic benefit set by which each of these plans can be described so that you can be protected from the skimming, so that you have the information to which you are entitled as a buyer at which you can compare all of these plans.

So what has happened to the concept of a basic or standard benefit package? It fell into the hands of the task force at the White House, and it was captured by special interests of all kinds. What was once a tool to help the market work better for people got subverted into a giant entitlement program.

Clinton had 61 pages of detailed and specific items and services. I am going to read to you just one of those pages. This is under "Durable Medical Equipment and Prosthetic and Orthotic Devices."

(a) COVERAGE.—The items and services described in this section are—

(1) durable medical equipment, including accessories and supplies necessary for repair, function, and maintenance of such equipment;

(2) prosthetic devices (other than dental devices) which replaces all or part of the function of an internal body organ (including colostomy bags and supplies directly related to colostomy care), including replacement of such devices;

(3) accessories and supplies which are used directly with a prosthetic device to achieve the therapeutic benefits of the prosthesis or to assure the proper functioning of the device;

(4) leg, arm, back, and neck braces;

(5) artificial legs, arms, and eyes, including replacements if required because of a change in the patient's physical condition; and

(6) fitting and training for use of the items described in paragraphs (1) through (5).

What is the point of all this? What is the point of all of this? What it does is handicap your doctor and your plan from being creative because once it is put in the law you cannot change it. We have not changed the statute and other descriptions of the health benefit plan since 1960. So once you decide colostomy bags are in and out that is it for colostomy bags.

So, this looks like Congress making promises to provide lots and lots of specific items and services. Whatever happened to the doctor making judgments? What happens to innovation? What happens when there is a new procedure or treatment?

My friend CONNIE MACK is right to be concerned about this. He expressed concerns on Saturday. It is bad enough that the President wanted Congress to draft benefit contracts in legislation, not satisfied with Congress creating a benefit contract in legislation. Senator MITCHELL goes even further. He has removed some legislative detail, but he creates a huge regulatory bureaucracy called the National Health Benefits Commission with a long list of powers and regulatory activity.

And instead of having all this detail, or quite all this detail, he creates his National Health Benefits Board which will:

First, promulgate regulations and establish guidelines;

Second, establish and update periodicity schedules for items and services, including clinical preventive services;

Third, design mental illness and substance abuse services;

Fourth, establish criteria for determinations of medical necessity or appropriateness;

Fifth, set up procedures for determinations of medical necessity and appropriateness;

Sixth, issue regulations and guidelines to be used to make determinations of whether items or services are medically necessary and appropriate;

Seventh, recommend to the Secretary specific areas for which priorities should be given to undertake clinical trials or establish practice guidelines;

Eighth, establish cost-sharing schedules;

Ninth, develop legislative proposals for modifications to the actuarial equivalence provisions;

Tenth, undertake studies on the costs of adding dental benefits for adults, in vitro fertilization coverage, substance abuse cost sharing.

This is not private insurance. It is a big Government bureaucracy just like all my colleagues have been describing it. It smells like HCFA, which is a huge bureaucracy employing over 4,000 people in Baltimore to price 7,000 medical services and nearly 500 hospital billing codes called DRG's.

What do we do now, Mr. President? We must go back to basics.

So do we junk the concept because it has been completely subverted by our left.

No, we go back to basic principles.

In his remarks Saturday my colleague CONNIE MACK praised the FEHBP program for the choices it provides.

FEHBP has a standard benefit package. I have just described it to you. It is one page in length, same size as the Finance Committee, only the Finance Committee has 12 amendments in it.

The FEHBP has an implementing body. It is called the Office of Personnel Management. OPM has approximately 118 people in it like the huge resources department in a large corporation.

It issues what looks like a set of guidelines or instructions. It is called a call letter. They take this one page that is in the statute and then they issue to all the health plans in this area, for example, something called a call letter, in which they invite plans to submit annually what their bids would be. That is the way it works.

It sets up the parameters upon which those health plans and insurers offering to see or compete in the FEHBP market, what conditions they must meet.

Lots of insurers bid to offer the categories of benefits along the parameters that OPM sets forth in their call letter. OPM is not a regulatory agency.

OPM has 117 employees working on all aspects of FEHPB. HCFA has 4,000. OPM does not decide what your doctor can and cannot do as to specific items and services, specific procedures and treatment. OPM is the human resources department of the company we all work for.

Thus, my friends CONNIE MACK and DON NICKLES see that program as one that is the epitome of choice.

So, Mr. President, this is the model for the mainstream moderate proposal. That was the intention in the original managed competition approach.

How does it work?

Congress sets forth the broad parameters—actuarial limits, broad categories of benefits, and a body like OPM to administer it.

That is it. The board does not regulate. The board does not substitute its decisions for those of doctors. The board, like OPM, defines the structure in which the choices are offered.

The result—the health plans, the doctors and the hospitals are free to provide the medically necessary or appropriate items, services, procedures that fall within the broad categories of benefits.

People can choose on the basis of price and quality, on the basis of satisfaction, proven performance—that is, results. They can choose with reasonable certainty that there is real coverage, not selection on the basis of gamesmanship which benefits only insurers.

No longer are people going to be cheated by insurers trying to cherry pick healthy people out of the pool and leave out the sick.

My colleague Senator MITCHELL assumes people cannot make choices of services in a health plan. It is true that they can't if we don't make benefits comparable, services understandable, and results public. This issue is not choice, the issue is informed choice through useful information.

The result: consumer protection; consumer information; more competition on price, quality, and satisfaction.

I want to point out to my colleagues that we are likely to have many, many amendments on the benefit package. They will likely require more items and services to be covered. These amendments came from the left and the right. On my side of the aisle, there was an amendment to include a specific service—flexible sigmoidoscopy—in the package. Later we heard angry voices from the barium enema supporters saying if you put in the flexible signoidoscopy benefit, you must put in the barium enema.

Others pushed to get specific providers groups into the benefit package. My colleague from South Carolina, Mr. THURMOND, had an amendment to include chiropractors.

On the Democratic side, mostly the push was for more specific benefits—more for women, more for children, more for the disabled, and so forth.

This is just a replay of State-mandated benefits elevated to the Federal level. States have already mandated that every benefit package include a whole series of benefits. States are telling DON NICKLES what he has to buy now. And many of those specific items and services—hair loss in Minnesota, for example, or massage therapy in Florida—are probably not high on DON's list or his family's list.

They will be packaged in politically irresistible ways—more for children, more for the disabled, more for women, more for mentally ill, more for whatever other group in the society has champions in Congress.

Members will be hard pressed to resist. We are not known for our ability to say no.

We are famous for mandating services, not paying for them. That is why the FEHBP and HMO and five pages of benefits are bound by dollar limitations. Guess which competing plans have to bid for services? Do not be fooled, Mr. President. This is politics as usual.

It is not surprising that the first two amendments that have been proposed are for more mandated benefits, one by our colleague from Connecticut, and the other by our colleague from Iowa, with whom I serve on the Labor Committee, and that one deals with people or persons with disabilities. That is where I want to conclude my remarks.

As I recall the amendment by my colleague, the amendment of the Senator from Connecticut reads as follows on behalf of himself, Mr. KENNEDY, and Mr. RIEGLE:

(1) IN GENERAL.—During the interim standards application period, a health plan sponsor may only issue or renew a health plan in a State if such plan covers clinical preventive services according to a periodicity schedule established under paragraph (3), including prenatal care, well baby care, and immunizations, for pregnant women and children without imposing cost-share requirements on such services.

The Secretary shall establish a schedule of periodicity that reflects the general, appropriate frequency with which clinical preventive services should be provided routinely to children.

Do you know what this is going to end up becoming, if she ever gets it out? It will probably take 10 years to get out the regulation, and by then, all of the rest of this bill will have been implemented. But if she ever gets it out, it is going to be the best guess about how many visits she ought to have to a doctor before a delivery, and how many you want to have afterwards.

I have to tell you, Mr. President, that is not the way the real world works. That is not the way the real world works.

And I am just a recent expert, having lived with my first grandchild, through my eldest son's first venture as a father. The poor kid is so nervous, and every day there is something wrong, where their kid is not doing this, not doing that; she is drooling at the mouth and they want to rush to see the doctor. Fortunately, they have a health plan and a relationship with the doctor that has a way to express that. They pick up the telephone, dial a number, describe what is wrong, and get some reassuring advice.

The Secretary is going to decide this.

There is a schedule of services and so forth. It is flexible, depending upon the kid, depending upon the language barriers, depending upon the culture, depending on so much.

Forty percent of Hawaii is Asian. I will bet you some of those children are somewhat different, and it is kind of different from the kind of clinic you

are going to find in a predominantly Spanish-speaking area—not drastically different, but hopefully different, adjusted to the family, the individual involved, and so forth.

That is really what you want. You do not want the Secretary of HHS deciding this, when you have this precious little thing, whether it is not yet born or just born. You want a relationship between the mother and a caregiver to develop the kind of care that little kid needs. You want a health plan that is intended to help the mom carry that child to term. That is what you want.

U Care—a Minnesota managed care program specifically designed to meet the needs of low-income individuals—will call women who miss prenatal checkups and, if necessary, will pay for taxis or babysitters so they can make their appointments. If the woman does not have a phone, they will even have one installed during the pregnancy.

Why? Because if that baby delivers a couple of months short, a pound and a half, something like that, think of what the costs are to the health plan.

Health Partners of Philadelphia has a program called "Little Partners." Trained women from the local community—and this is why you take into this the race, culture, and community, in the most appropriate sense of the word—trained women from the local community make home visits to pregnant women and infants through their first year of life.

Other plans lure patients to their appointments by providing free diaper service, baby care seats, or baby bunting. Baltimore's Prudential Health Care Plan found that what works best for their enrollees is to pay low-income pregnant women $10—pay them $10—every time they come in for a prenatal visit.

Now, there are some folks over here who would say, "Why do they have to pay them to come in? They ought to pay to come in."

You know, this is the way it is. If you care about the kids, you have to go out of your way to care about the mom. And to have the Secretary of HHS decide by some rule and some regulation that all moms are alike and all pregnancies are the same and we can put it into law does not make any sense.

But you cannot tell that from the bleeding-heart rhetoric which we have been hearing for the last 3 days from our colleagues—we are not doing enough for mothers and children, and infant mortality.

I can show you infant mortality statistics that come down when you give a health plan—I got them from Kaiser; I can get them from other people—when you give the plan an incentive to keep moms healthy, they go out of their way to do it.

Mr. President, I know this little explanation went longer than I thought. I am very grateful to you and other Members, and I am grateful, particularly, to staff for staying through this whole thing and allowing me to finish my comments.

RECESS UNTIL TOMORROW AT 9:15 A.M.

Mr. DURENBERGER. Mr. President, I ask unanimous consent that the Senate stand in recess under the previous order.

There being no objection, the Senate, at 9:55 p.m., recessed until Tuesday, August 16, 1994, at 9:15 a.m.

NOMINATIONS

Executive nominations received by the Senate August 15, 1994:

MORRIS K. UDALL SCHOLARSHIP AND EXCELLENCE IN NATIONAL ENVIRONMENTAL POLICY FOUNDATION

KENNETH BURTON, OF VIRGINIA, TO BE A MEMBER OF THE BOARD OF TRUSTEES OF THE MORRIS K. UDALL SCHOLARSHIP AND EXCELLENCE IN NATIONAL ENVIRONMENTAL POLICY FOUNDATION FOR A TERM OF 2 YEARS. (NEW POSITION.)

D. MICHAEL RAPPOPORT, OF ARIZONA, TO BE A MEMBER OF THE BOARD OF TRUSTEES OF THE MORRIS K. UDALL SCHOLARSHIP AND EXCELLENCE IN NATIONAL ENVIRONMENTAL POLICY FOUNDATION FOR A TERM OF 2 YEARS. (NEW POSITION.)

EXTENSIONS OF REMARKS

SENATE COMMITTEE MEETINGS

Title IV of Senate Resolution 4, agreed to by the Senate on February 4, 1977, calls for establishment of a system for a computerized schedule of all meetings and hearings of Senate committees, subcommittees, joint committees, and committees of conference. This title requires all such committees to notify the Office of the Senate Daily Digest—designated by the Rules Committee—of the time, place, and purpose of the meetings, when scheduled, and any cancellations or changes in the meetings as they occur.

As an additional procedure along with the computerization of this information, the Office of the Senate Daily Digest will prepare this information for printing in the Extensions of Remarks section of the CONGRESSIONAL RECORD on Monday and Wednesday of each week.

Meetings scheduled for Tuesday, August 16, 1994, may be found in the Daily Digest of today's RECORD.

MEETINGS SCHEDULED

AUGUST 17

9:00 a.m.
Labor and Human Resources
Business meeting, to mark up S. 1821, Comprehensive Fetal Alcohol Syndrome Prevention Act, S. 1781, Black Lung Benefits Restoration Act, S. 1037, Justice for Wards Cove Workers Act, proposed legislation to reform civil and criminal money penalties, and proposed legislation authorizing funds for the Nurse Education Act, and to consider pending nominations.
SD–430

2:00 p.m.
Judiciary
To hold hearings on the nominations of William C. Bryson, of Maryland, to be U.S. Circuit Judge for the Federal Circuit, Salvador E. Casellas and Daniel R. Dominguez, each to be a U.S. District Judge for the District of Puerto Rico, and Sarah S. Vance, to be U.S. District Judge for the Eastern District of Louisiana.
SD–226

AUGUST 18

9:30 a.m.
Armed Services
To resume hearings to examine the military implications of the Chemical Weapons Convention (Treaty Doc. 103–21).
SR–222

Judiciary
To hold hearings on the nomination of Lois Jane Schiffer, of the District of Columbia, to be an Assistant Attorney General, Department of Justice.
SD–226

10:00 a.m.
Foreign Relations
Business meeting, to mark up S. 1329, to provide an investigation of the whereabouts of the U.S. citizens and others who have been missing from Cyprus since 1974, and to consider H. Con. Res. 215, honoring James Norman Hall and recognizing his outstanding contributions to the U.S. and the South Pacific, the Agreement to Promote Compliance with International Conservation and Management Measures by Fishing Vessels on the High Seas (Treaty Doc. 103–24), and pending nominations.
SD–419

Judiciary
To hold hearings on the nominations of Nancy E. Gist, of Massachusetts, to be Director of the Bureau of Justice Assistance, Laurie O. Robinson, of the District of Columbia, to be Assistant Attorney General for the Office of Justice Programs, Jan M. Chaiken, of Massachusetts, to be Director of the Bureau of Justice Statistics, and Jeremy Travis, of New York, to be Director of the National Institute of Justice, all of the Department of Justice.
SD–628

AUGUST 29

10:00 a.m.
Environment and Public Works
Clean Air and Nuclear Regulation Subcommittee
To hold hearings to examine the potential health effects resulting from radium nasopharyngeal irradiation treatment.
SD–406